

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 15434	
1. DECEASED NAME (TYPE OR PRINT) <b>Calvin Alexander</b>							2a. DATE KNOWN OF DEATH <b>6-3</b>		2b. HOUR <b>19 79</b>		
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH <b>10-27-44</b>	6. AGE (IN YEARS) <b>34</b>	7. IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. <b>0</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD <b>6-3</b>		2d. HOUR <b>19 79</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b>			MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6413 86th Avenue</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>New Carrollton</b>		13c. CITY OR TOWN							
14. FATHER'S NAME <b>Pinky Alexander</b>				15. MOTHER'S MAIDEN NAME <b>Margaret Monteith</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>578 56 4311</b>		17. INFORMANT ADDRESS <b>Mrs. Marion Alexander-wife</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic corded vascular disease</b> 4292 (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Obesity</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>				M.D. <b>Deputy</b>				DATE SIGNED <b>6-4-79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez</b>				ADDRESS <b>5009 Bayburn Ct., Crook Springs, Md 21031</b>							
23a. BURIAL, CREMATION, OR REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/8/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Stewart</b>				24b. ADDRESS <b>Funeral Home-4001 Benning Road, NE.</b>				25a. DATE AND BY REGISTER <b>JUN 11 1979</b>		25b. REGISTRAR'S SIGNATURE <b>John H. Stewart</b>	

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Chapman



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 5 4 3 5

1. DECEASED NAME (TYPE OR PRINT) <i>Alara</i>		FIRST <i>Archinal</i>		LAST <i>Archinal</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>June 11, 1979</i>		2b. HOUR M	
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>March 20 1903</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>76</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>N.J.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George Co.</i> MD			
10. CITY OR TOWN OF DEATH <i>Greenbelt</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Greenbelt Conv. Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>		13b. COUNTY <i>P.G.</i>		13c. CITY OR TOWN <i>Bowie</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>Craydon Ave.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ernest</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Marie</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES					
16b. SOCIAL SECURITY NO <i>139-07-6741</i>		17. INFORMANT <i>Lou Archinal</i>		ADDRESS <i>20 Willow Ct. Shrewsbury N.J.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>septicemia</i> 4349 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>due large decubit ulcers</i> (c) <i>decreased defense of clearing 8 weeks prior</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> <i>8 months</i> <i>3 years</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>pericardial rupture, HX needle stab wound</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>July 7th</i> 19 <i>77</i> , to <i>June 11th</i> 19 <i>79</i> , that (I) (we) lost saw the deceased alive on <i>June 10th</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.									
22b. SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>June 11/1979</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Hordashty J.H.</i>		22e. ADDRESS <i>12 Ridgely Annex.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6/14/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>East Hanover N.J.</i>			
24. FUNERAL DIRECTOR NAME <i>Hordashty J.H.</i>		ADDRESS <i>12 Ridgely Annex.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 15 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			





Medical Examiner Notified.

TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 5 4 3 6

1. FOR STATE REGISTRAR		7. DATE OF DEATH		8. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. MONTH DAY YEAR		2b. HOUR	
ANNA = CATHERINE ARMSTRONG		JUNE 10, 1979		10:38A M	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	Cauc.	MONTH DAY YEAR Sept. 22, 1906	72 YRS	MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	U.S.A.		PRINCE GEORGE COUNTY MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
LANHAM, MD.	DOCTORS' HOSPITAL OF P. G. COUNTY	Nurse	Nursing		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13a. INSIDE CITY LIMITS?	13b. STREET ADDRESS			
13a. STATE 13b. COUNTY Maryland Prince Georges Bladensburg	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	5999 Emerson Street			
14 FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST William Armstrong	FIRST MIDDLE LAST Cora Todd				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT	ADDRESS		
no	224-42-3105A	GEORGIA ARMSTRONG (sister)	5999 EMERSON ST. #413 BLADENSBURG, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction, aspiration</u>					
410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumonia, sepsis and shock</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardiovascular Disease</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Urinary tract infection.</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from <u>June 9, 1979</u> to <u>June 10, 1979</u> , that (b) (we) lost saw the deceased alive on <u>June 10, 1979</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (c) (we) did (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
<u>CHIN-CHUAN Hsu</u>	M.D.		6/10/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
CHIN-CHUAN Hsu, M.D.	6905 Baltimore Blvd Collegepark, Md 20740				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	June 13, 1979	August Memo. Cemetery	Fishersville, Virginia		
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Robert G. Beall Funeral Home 9013 Annapolis Road, Lanham, Maryland	JUN 12 1979		<u>[Signature]</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO. 15437							
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ERNEST A. Bamberger			2a DATE OF DEATH MONTH DAY YEAR 06 27 79				2b HOUR 11:15A.M.			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 12 06 16		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.				
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTHERN MARYLAND HOSPITAL CENTER				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired (SUPERVISOR)		12b KIND OF BUSINESS OR INDUSTRY DC. DEPT. OF HHS		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.			13b COUNTY Pr. Geo.		13c CITY OR TOWN Forrestville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 2503 Senator Ave.	
14 FATHER'S NAME FIRST MIDDLE LAST MAX BAMBERGER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JEANETTE RICHHEIMER							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT ADDRESS DORIS L. BAMBERGER		SAME AS ITEM # 13			
<p>18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1509 Cancer of Esophagus with metastasis 1 yr - DUE TO, OR AS A CONSEQUENCE OF (b): Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c):</p>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 6-27-79 to 6-27-79, that (I) (we) last saw the deceased alive on 6-27-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) saw the body after death.										
22a. SIGNATURE Daniel Howell, M.D.			DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6-27-79			
22b. PHYSICIAN'S NAME (TYPE OR PRINT)			22d. ADDRESS WALDORF, Md. CHARLES PROFESSIONAL CENTER							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE JUNE 29, 1979		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREM.		23d. LOCATION CITY OR TOWN COUNTY STATE SWITLAND, PG.C. Md.				
24. FUNERAL DIRECTOR NAME W.W. CHAMBERS Co.			ADDRESS 517 11TH ST. SE WASH. DC		25a. DATE REC'D. BY REGISTRAR JUL 6 1979		25b. REGISTRAR'S SIGNATURE History McBrady			

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15438

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR			
VERA			JEAN	BANKS		06			01	79	2:02 P.M.				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)			7 UNDER 1 YEAR		7 UNDER 24 HRS				
Female		Black		06 18 49		29			YRS		MONTHS DAYS HOURS MIN.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		U.S.A.				Prince Georges MD.									
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Clinton		Southern Maryland Hospital Bd Ed., P.G.										P.E.Tch.			
13a STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS					
Md.				Pr. Geo.		Brandywine		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt.1 Box 275					
14 FATHER'S NAME						15 MOTHER'S MAIDEN NAME									
John S. Washington						Delphine Gray									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS									
No				215-54-5718		John & Delphine Washington SAA									
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio Respiratory arrest</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>															
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
(-) (-) (-)				St. Peter's Ch. Cem.				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>5-30</u> , 19 <u>79</u> , to <u>6-1</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6-1</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b SIGNATURE								DEGREE		22c DATE SIGNED					
Nirmala Khot Fernbach MD								ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		6-1-79					
22d PHYSICIAN'S NAME (TYPE OR PRINT)								22e ADDRESS							
NIRMALA KHOT FERNBACH								7726 FINNS LANE LANHAM Md 20801							
23a BURIAL, CREMATION, REMOVAL (SPR)				23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION CITY OR TOWN COUNTY STATE					
Burial				6-5-79		St. Peter's Ch. Cem.				Bryanyown Chas. Md.					
24 FUNERAL DIRECTOR NAME								ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Adams Funeral Home								Quasson Md.		JUN 5 1979		R. J. K. K. K.			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO. 15439					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CAROL ANN BATTLESON</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 29, 1979</b>					2b. HOUR <b>1:40A M</b>
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>OCTOBER 21, 1948</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>30</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>ANDREWS AFB, MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MALCOLM GROW USAF MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TEACHING</b>		
13a. STATE <b>ARIZONA</b>		13b. COUNTY		13c. CITY OR TOWN <b>LAKE HAUASU</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>25 COMMANDER DRIVE</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN WILLS TUTHILL</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ERNA MARGARET LUEDERS</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>						
16a. SOCIAL SECURITY NO. <b>117-38-2420</b>		17. INFORMANT Husband. ADDRESS Washington, D.C. <b>Charles E. Battleson, 2801 New Mexico Ave. NW</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Usual Encephalitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 mo.</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pneumonia</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>May 19 79</b> , to <b>29 Jun 79</b> , that (I) (we) lost saw the deceased alive on <b>29 Jun 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE OF PHYSICIAN		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>29 Jun 79</b>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SUSAN P. ABERNATHY, CAPT, USAF, MC</b>		22f. ADDRESS <b>MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB, MD 20331</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>6/30/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P.G. Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>Jos. Gawler's Sons</b>		ADDRESS <b>5130 Wisconsin Av. NW Wash. D.C.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 6 1979</b>		25b. REGISTRAR'S SIGNATURE <i>Richard M. Brady</i>				

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111-44-500

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HAIR MEDICAL CENTER

ANDERSON APT, NO 20031

SUSAN E. ANDERSON, CAPT, USAF, NO 20031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15440

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR		P.	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH	
Sadie L Bean		Female		White		Nov. 28 1894	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
U.S. Maryland		United States				Prince George MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hyattsville		Sacred Heart Home		Registered Nurse			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS	
Md.		Mont.		Silver Sp.		9039 Sliquo Creek Parkway	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
George H. Bean		Mary Jane Hamilton.		No		578-46-6234	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis &amp; myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>one day</u> <u>18 months</u>	
Sacred Heart Home, Hyattsville, Md.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 1</u> , 19 <u>77</u> , to <u>JUNE 30</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>JUNE 30</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Thomas F. Collins</u>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6-30-79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. DATE		23b. NAME OF CEMETERY OR CREMATORY	
THOMAS F. COLLINS		2600 - QUEEN'S CHAPEL RD				23c. LOCATION (CITY OR TOWN) COUNTY STATE	
23d. BURIAL, CREMATION, REMOVAL (SPECIFY)		23e. DATE		23f. NAME OF CEMETERY OR CREMATORY		23g. LOCATION (CITY OR TOWN) COUNTY STATE	
Burial		July 2, 1979		23h. NAME OF CEMETERY OR CREMATORY		23i. LOCATION (CITY OR TOWN) COUNTY STATE	
24. FUNERAL DIRECTOR		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Matthews Walters		JUL 5 1979		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Washington DC 20012				JUL 5 1979		25b. REGISTRAR'S SIGNATURE	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9 15441

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Giulia Bedoni</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-3-79</b>			2b. HOUR <b>11:15 P</b>				
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 6 1898</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Holy</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George</b> MD.				
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Nursing Home</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>			13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Lanham</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS <b>6556 Princess Garden Pkwy.</b>										
14 FATHER'S NAME FIRST MIDDLE LAST <b>Ubaldo Maiolatesi</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Antoinette Mandrelli</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>214 70 2757</b>		17 INFORMANT ADDRESS <b>Carl Bedoni (Son) same as above</b>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cardiovascular collapse</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>cardiac arrhythmias -</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>1972</b> , 19 <b>6/3</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/1</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Robert W. Dolinas, M.D., F.A.C.P.</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/4/1979</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>9801 Georgia Avenue</b>						22e. ADDRESS <b>9801 Georgia Ave. S.S. Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/6/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery Brentwood</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>PG Md.</b>			
24 FUNERAL DIRECTOR NAME ADDRESS <b>Hines/Rinaldi F.H. 11800 N.H. Ave. Silver Spring, Md.</b>						25a. FILED BY <b>JUN 6 1979</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 5 4 4 2

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Nettie B. BELTON		F		Blk	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
Oct. 16, 13		65 YRS.		Prince George County MD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
S. C.		USA			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Glenn Dale		Glenn Dale Hospital		Housewife	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
D. C.				Wash.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Ben		Della		No	
17. INFORMANT		18. CAUSE OF DEATH		19. SOCIAL SECURITY NO.	
James W. Belton (son)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident with right hemi- paresis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension; pulmonary tuberculosis, far advanced; decubitus ulcer</u>		Not Stated	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 25</u> , 19 <u>78</u> , to <u>June 20</u> , 19 <u>79</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>June 20</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (we) did not view the body after death.		22b. SIGNATURE <u>James W. Wills, M.D.</u>		22c. DATE SIGNED June 20, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
James W. Wills, M.D.		Glenn Dale Hospital Glenn Dale, Maryland 20769		Burial	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
June 26, 1979		Harmony Cem.		Landover Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Watson F.H. Inc.		Wash. D. C. 3435 14th St., N. W.		JUN 23 1979 <u>Pinkney McCreedy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15443

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		6/ 3/ 1979		8:05AM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
Female		White		MONTH DAY YEAR 11/3/1883		95 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Sweden		Sweden				Prince George's MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Mitchellville		Villa Rosa Nursing Home		Masseuse		Health Care	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
DC				Wash.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
August		Eda		No		677-48-1374	
17 INFORMANT		ADDRESS		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Robert F. Mahar		5625 Western Ave. Wash. DC		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Thrombus-embolism (cerebral)</u> 4340 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Fibillation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
<u>gangrene left leg.</u>		5-23-79		<u>gangrene left leg</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		HOUR A.M. MONTH DAY YEAR P.M. 19				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		22c. DATE SIGNED	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET CITY OR TOWN COUNTY STATE		6/3/1979	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-12</u> 19 <u>79</u> , to <u>4-27</u> 19 <u>79</u> , that (I) (we) lost		22b. SIGNATURE		DEGREE		ATTENDING MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	
saw the deceased alive on <u>4-27</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		Ciro A. Montanez		3308 Dodge Park Rd.-Landover, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		6/7/1979		Oak Hill Cemetery		Washington, D.C.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
JOSEPH GAWLER'S SONS INC.		JUN 8 1979		[Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 79 15444							
1. DECEASED NAME (TYPE OR PRINT) <b>CYRIL J. BOBISH</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>June 06 01 79</b>			2b. HOUR <b>9:15A</b>	
SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>02 17 32</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>47</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges County MD</b>			
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	
13a. STATE <b>Md.</b>					13b. CITY OR TOWN <b>St. Marys Charlotte Hall</b>		13c. STREET ADDRESS <b>Rt. 1 Box 678</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Bobish</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Olive Witkowski</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korea 187-24-7785</b>		17. INFORMANT ADDRESS <b>Frances Bobish, Wife Same as 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA OF ② KIDNEY</b> <b>1890</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost b) _____ DUE TO, OR AS A CONSEQUENCE OF c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 mos</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>JANUARY 19 79</b> to <b>MAY 31 19 79</b> , that (I) (we) lost view of the deceased on <b>MAY 31 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>James G. Brown</b>				DEGREE		22c. DATE SIGNED <b>6/1/79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES A BROWN MD</b>				22e. ADDRESS <b>6521 BACKREST RD HYATTSVILLE MD 20872</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 5, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stephens Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Shenandoah Penna</b>			
24. FUNERAL DIRECTOR NAME <b>Capitol Funeral Ser.</b>				ADDRESS <b>Fairfax, Va.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 5 1979</b>			

1941



1941

Medical Examiner  
Notified

8

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

(M)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					7 9 1 5 4 4 5 REG. NO.						
1 DECEASED NAME (TYPE OR PRINT) John K. Brann					2a DATE OF DEATH MONTH DAY YEAR June 13, 1979					2b HOUR 12:30P	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb 5, 1896		6 AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George Co. MD					
10 CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b KIND OF BUSINESS OR INDUSTRY U.S. Gov.			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b COUNTY Howard		13c CITY OR TOWN Savage		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 8905 Washington St.			
14 FATHER'S NAME FIRST MIDDLE LAST William Brann					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes					16b SOCIAL SECURITY NO. WWI		17 INFORMANT ADDRESS Land Dora Brann same as #13				
18 CAUSE OF DEATH Enter only one cause for line (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF <i>Coronary Sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF <i>Arterio Sclerosis Heart Dam</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from June 13, 1979, to June 13, 1979, that (I) (we) last saw the deceased alive on June 13, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b SIGNATURE <i>Dante H. Highland, M.D.</i>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		19. DATE SIGNED June 13, 1979			
22d PHYSICIAN'S NAME (TYPE OR PRINT)					22e ADDRESS						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 6/16/79		23c NAME OF CEMETERY OR CREMATORY Savage Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Savage, Howard, Maryland					
24 FUNERAL DIRECTOR FLECK LAUREL FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20810					25a DATE REC'D. BY REGISTRAR JUN 15 1979		25b REGISTRAR'S SIGNATURE <i>Robert McBrady</i>				

BP

0 0 0 1 1 1



Handwritten text, possibly a signature or name, appearing as "John ...".

Handwritten text, possibly a date or number, appearing as "13".

Handwritten text, possibly a signature or name, appearing as "John ...".

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT MUST BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201.

TO MEDICAL EXAMINER: WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. EXECUTE THE CERTIFICATE.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15446  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Mary Magdolene BREWER</i>				2a. DATE KNOWN OF DEATH ESTIMATED <i>6-17-79</i>				7b. HOUR M							
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YR <i>Nov. 1, 1906</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>72</i> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD <i>6-17-79</i>		7d. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George's</i> MD			
10. CITY OR TOWN OF DEATH <i>Cheverly</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince George's General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Presser</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Cleaners</i>			
13a. STATE <i>Maryland</i>				13b. COUNTY <i>P.G. Co.</i>		13c. CITY OR TOWN <i>College Park</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>8111 51st Avenue</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>George Joseph Brooks</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rosa Maude Mickey</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>217-03-2492</i>		17. INFORMANT ADDRESS <i>Pearl Briscoe 8113 51st Ave. Maryland</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intense atherosclerotic cardiovascular disease</i> <i>4292</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TIME (SPECIFY) <i>Regular</i>				MEDICAL EXAMINER <i>Augusto P. Rodriguez</i>				DATE SIGNED <i>6-17-79</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez</i>				ADDRESS <i>5009 Raymont Ct., Camp Springs, Md 20746</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>6/21/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Maryland National Cemetery</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Laurel, P.G. Co., Maryland</i>					
24. FUNERAL DIRECTOR NAME <i>Chambers Funeral Home</i>				ADDRESS <i>Riverdale, Maryland</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 28 1979</i>				25b. REGISTRAR'S SIGNATURE <i>Hickey McCready</i>			

7000





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79 15447

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Zora Elizabeth Brightwell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 23 79</b>			2b. HOUR <b>10:24<sup>a</sup></b>					
3. SEX <b>Female</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 2 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PG</b> MD.					
10. CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Md. Hosp. Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSE KEEPER</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. COUNTY <b>CALVERT</b>		13c. CITY OR TOWN <b>PR. FED.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>ARMORY ROAD</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LAURA</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-38-3440</b>		
17. INFORMANT ADDRESS <b>BOX 444</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>atherosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>40 years</b> <b>years</b>			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).					
19a. DATE OF OPERATION <b>6/17/79</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>arterial occlusion ptly</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>6/16, 19 79</b> to <b>6/23, 19 79</b> , that (I) (we) last saw the deceased alive on <b>6/23/79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.											
22b. SIGNATURE <b>William S. Jones MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>6-23-79</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WM S. JONES</b>				22e. ADDRESS <b>277. S. WASH ST ALEX VA</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JUNE 26, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESLEY METH. CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>PR. FRED CALVERT MD.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>DONALD V. BORGWARDT</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>L. H. H. H.</b>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMM - 16 60M 1/75  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Dorothy T. BRISCOE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>May 27, 1979</b>			2b. HOUR <b>11:30</b>			
3 SEX <b>F</b>		4 RACE <b>N</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>4-5-1905</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>74</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George County</b>			
10 CITY OR TOWN OF DEATH <b>Glem Dale</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Glenn Dale Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>D.C.</b>		13b. COUNTY <b>D.C.</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4612 Hunt Pl. N.E.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Lee</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT ADDRESS <b>Bethan Moffatt 29-Scout Pl. N.E.</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Brain Syndrome secondary to diffuse brain atrophy</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 26</b> , 19 <b>78</b> , to <b>May 27</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> (we) saw the deceased alive on <b>May 27</b> , 19 <b>79</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.									
22b. SIGNATURE <b>James W. Wills</b>				DEGREE <b>Attending Physician</b>		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>May 27, 1979</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James W. Wills, M.D.</b>				22e. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland 20769</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <b>6-1-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Southland Md</b>			
24. FUNERAL DIRECTOR NAME <b>145 Washington</b>				ADDRESS <b>4925 Nannie H. Burroughs Ave. N</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 6 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McCreedy</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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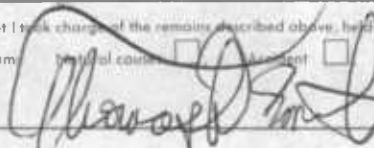

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79 15449			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MILTON RAYMOND Brittain</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>June 24, 1979</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 18, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D C</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Pro Georges County</b>	
10. CITY OR TOWN OF DEATH <b>Adelphi</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Parts clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Auto dealer</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY <b>Md Pro Georges Beltsville</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>11913 Franklin street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Milton P Brittain</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary A Johnston</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577 07 0316</b>		17. INFORMANT ADDRESS <b>Etta Mae Schaffer Beltsville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>COMA</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Brain tumor</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Carcinoma of the Lung</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b> <b>1 yr</b> <b>2 yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 24</b> 19 <b>78</b> , to <b>24 June</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>2 June</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Armando A. Miranda M.D.</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>24 June 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARMANDO A. MIRANDA</b>				22e. ADDRESS <b>1140 Varnum St N E Washington D C</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 28, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D C</b>	
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons P A Hyattsville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Crady</b>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										15450 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>John Weens Brooks</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>6 3 1979</b>		2b. HOUR <b>M</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 8, 1918</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>61</b> YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>6 3 1979</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County, MD</b>	
10. CITY OR TOWN OF DEATH <b>Laurel</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Laurel-Beltsville Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>100 - 9th street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Richley Holly</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Regina Brooks</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>578 38 0101</b>		17. INFORMANT ADDRESS <b>William O. Thomas Washington, D.C. 804 -20th St NE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stabwound of chest</b> 966- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20002</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>5:46 P.M. 6 3 1979</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject stabbed by assailant</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>house</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>100 9th St. Laurel P.G. MD</b>					
22a. I certify that I took charge of the remains described above, hereon death resulted from <input type="checkbox"/> natural cause <input type="checkbox"/> accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Deputy Chief</b>				DATE SIGNED <b>6/4/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn Sb. Balto. MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>June 8, 1979</b>		23c. NAME OF CEMETERY OR CREMATION LOCATION <b>Charles Memorial Leonardtown St. Mary's, Md.</b>					
24. FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley</b>				ADDRESS <b>Leonardtown, Maryland</b>		25a. DATE REC'D BY REGISTRAR <b>JUN 12 1979</b>		25b. REGISTRAR'S SIGNATURE 			



## Medical Examiner Notified &amp; Released

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 5 4 5 1									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Elton Wason Bruce								06-18-79		5.30P.M.	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		June 18, 1979						1	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
CHEVERLY		PRINCE GEORGE'S GENERAL HOSPITAL		none		none					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Pr. Geo's		Laurel				14819 Bowie Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Robert J. Bruce		Yu Yumei Bruce									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No		none		Robert J. Bruce (Father) same as blk 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immature Infant Male</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
7651											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6/18</u> 19 <u>79</u> , to <u>6/18</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/18</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>view the body after death.</u>											
22b. SIGNATURE		DEGREE				22c. DATE SIGNED					
Ruth L. Steerman, M.D.						6/19/79					
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Ruth L. Steerman M. D.		PGGH, Cheverly, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		6/25/79		Ft. Lincoln Cem		Brentwood P. G. Md.					
24. FUNERAL DIRECTOR NAME		25. DATE REC'D. BY REGISTRAR				25. REGISTRAR'S SIGNATURE					
Francis Gasch's Sons, PA Hyattsville, Md.		JUN 22 1979				[Signature]					



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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15452	
1. DECEASED NAME (TYPE OR PRINT) FRED L BRUECKNER			2a. DATE OF DEATH MONTH DAY YEAR 06 04 79			2b. HOUR 7:10 AM					
3. SEX M Male		4. RACE W White		5. DATE OF BIRTH MONTH DAY YEAR 7 09 12		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Restaurant Bus		12b. KIND OF BUSINESS OR INDUSTRY Restaurant			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Pr. George's		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1204 Swann Harbor Circle	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Brueckner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Foley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII 133-12-4049		17. INFORMANT Barbara Martinelli				ADDRESS 1226 Palmer Road Oxon Hill, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung 1619 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 1 July 1976		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9-06 1973, to 6-4 1979, that (I) (we) lost saw the deceased alive on 5-18 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE C. King				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/4/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES C KING				22e. ADDRESS 6005 Landover Rd., Cheverly, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/7/79		23c. NAME OF CEMETERY OR CREMATORY Resurrection		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton Pr. George Maryland					
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home				ADDRESS 6160 Oxon Hill Oxon Hill, Md.		24a. DATE REC'D BY REGISTRAR JUN 15 1979		24b. REGISTRAR'S SIGNATURE F. J. H. H. H.			

20.2.08

10



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
1/VR A15 ME (5)  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15453  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH KNOWN ESTI- MATED			<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR
George Francis Burch						6 15 1979						M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR	2d. HOUR
male	white	July 31, 1929	49 YRS.					6 15 1979				11:22 p.m.
7a. BIRTHPLACE (STATE OR COUNTRY (PRINT))		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.					Prince George County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George Hospital				Farmer			Farm			
13a. STATE			13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				
Maryland			Charles	Hughesville				Rt. #1 Box 339				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
George W. Burch			Mary Murphy									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
NO			218-24-6322		James H. Burch same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple visceral and skeletal injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
10:10 PM 6/15 1979			pedestrian struck by automobile									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
			street			Route #5, North of Rt. 231, Hughesville, ChasCo. MD						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED						
Virginia L. Dolan			M.D. Assistant			6/16/79						
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS									
Virginia L. Dolan, M.D.			111 Penn Street, Baltimore, MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			6-19-79		St. Mary's Cem.			Bryantown, Charles Md.				
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR						
Huntt Funeral Home Waldorf, Maryland						JUN 22 1979						





Must report home abroad, foreign

19-19-19, of, 1919, 1919

MAY 1919

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 15454	
1- FOR STATE REGISTRAR						2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) <b>DENNIS C BURROUGHS</b>						ESTI-MATED <input checked="" type="checkbox"/> 6 15 1979				M	
3. SEX <b>ma le</b>		4. RACE <b>white</b>		5. DATE OF BIRTH (MONTH DAY YEAR) <b>Nov 2, 1944</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>34</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 6 15 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Lanham</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctor's Hospital of Pr. Geo.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Statistical</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US Gov't</b>			
13a. STATE <b>Maryland</b>		13b. CITY <b>Pr. Geo's</b>		13c. CITY OR TOWN <b>Glenn Dale</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3311 Glenn Dale Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hazel Burroughs</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. <b>Vietnam 232-70-0133</b>		17. INFORMANT ADDRESS <b>same as Jeannette G. Burroughs (wife) blk 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Ruptured Berry Aneurysm at base of the brain</b> IMMEDIATE CAUSE (a) <b>430-</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>				M.D. <b>Assistant</b>				DATE SIGNED <b>6/16/79</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn Street, Balto., MD 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6/18/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pr. Geo Md.</b>			
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons, PA Hyattsville, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

Item #5 per phone call w/Fun. Home STATE OF MARYLAND 6/12/79 rc DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 15455	
1- DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES W BURROUGHS</b>		2a DATE OF DEATH MONTH DAY YEAR <b>06 04 79</b>	
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>	
5 DATE OF BIRTH MONTH DAY YEAR <b>09 14 1895</b>		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>84/ 83</b> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> MD.	
10 CITY OR TOWN OF DEATH <b>Clinton</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hospital</b>	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>Md.</b>		13b COUNTY <b>St. Marys</b>	
13c CITY OR TOWN <b>Hollywood</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e STREET ADDRESS <b>Rt. 1 Box 85</b>		14 FATHER'S NAME FIRST MIDDLE LAST <b>James William Burroughs</b>	
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Jane Thompson</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>	
16b SOCIAL SECURITY NO. <b>213-22-1020</b>		17 INFORMANT ADDRESS <b>Martha R. Burroughs Rt. 1, Box 85 Hollywood, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> (b) <b>Coronary Artery Disease</b> (c) <b>Arteriosclerotic Cardio-vascular Disease</b> 4149		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>5-25</b> , 19 <b>79</b> , to <b>6-4</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6-4</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE <b>James R. Fishman</b>		22c DATE SIGNED <b>6/4/79</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES R. FISHMAN</b>		22e ADDRESS <b>7508 Surratt Rd. Clinton Md.</b>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>June 7, 1979</b>	
23c NAME OF CEMETERY OR CREMATORY <b>St Johns</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Hollywood, St Mary's Md.</b>	
24 FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley</b>		25a DATE REC'D. BY REGISTRAR <b>JUN 11 1979</b>	
ADDRESS <b>Leonardtown, Maryland</b>		REGISTRAR SIGNATURE <b>Anthony M. Burroughs</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9		1 5 4 5 6		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JOHN H BURTON, JR.			2a. DATE OF DEATH MONTH DAY YEAR 06 02 79			2b. HOUR 7:45 A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 28, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Maintenance Supervisor		12b. KIND OF BUSINESS OR INDUSTRY A.F.B.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.		13c. CITY OR TOWN Anne Arundel Lothian		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5296 Sands Road			
14. FATHER'S NAME FIRST MIDDLE LAST John H. Burton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine -- S Repp		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unk.					
16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT 5296 Sands Rd., Helen M. Burton-Lothian, Md. 20820							
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Respiratory Failure</u> 1510 DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic Liver Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma ESOPHAGO-GASTRIC</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day 3 wks 3 wks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>DIABETES MELLITUS</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/14</u> 19 <u>79</u> to <u>6/2</u> 19 <u>79</u> , that (I) (was) lost saw the deceased alive on <u>JUNE 2</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.									
22b. SIGNATURE <u>Samuel J. N. Sugar</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/2/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL J. N. SUGAR MD		22e. ADDRESS 4637 EASTERN AVE WASHINGTON DC 20018							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/5/79		23c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Forestville (Pr. Geo's) Md.			
24. FUNERAL DIRECTOR Richard A. Coleman - Upper Marlboro, Funeral Home - Maryland 20870				25a. DATE REC'D BY REGISTRAR JUN 12 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
1. FOR STATE REGISTRAR			7 9 1 5 4 5 7				REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
WARREN HARDING CAPLINGER						June 11, 1979			11:50pM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		White		August 11, 1923		55 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U.S.A.				Pr. Geo. Co. MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Lanham		Pr. Geo. Doctor's Hospital				Equip. Mechanic			C&P Phone Co.		
13a. STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS				
Md.			P.G.		Lanham YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5619 Ellerbie Court				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
John W. Caplinger			Frances V. Robey								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS Address Same as No # 13c.			
Yes			W.W.II		577-26-8177		Helen M. Caplinger				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>MASSIVE UPPER GASTROINTESTINAL HEMORRHAGE</u>										1 HR	
DUE TO (b) <u>METASTATIC EPIDERMAL CARCINOMA OF ESOPHAGUS</u>										6 mos	
DUE TO (c) OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <u>DECEMBER</u> 19 <u>78</u> , to <u>JUNE 11</u> , 19 <u>79</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>JUNE 11</u> , 19 <u>79</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) ( <del>did</del> ) ( <del>do not</del> ) view the body after death.											
22b. SIGNATURE			DEGREE			22c. DATE SIGNED					
<u>James G. Brown MD</u>						6/12/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
<u>JAMES A. BROWN MD</u>			<u>6525 BELCREST RD HYATTSVILLE, MD 20782</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			6-14-79		Wash. Natl. Cemetery		Suitland P.G. Md.				
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. RECORDING SIGNATURE			
F. Gasch's Sons F.H. P.A. Hyattsville, Md.						JUN 15 1979		<u>James G. Brown</u>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. BEFORE EXECUTING THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
1VR A15 ME (5)  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15458

1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) <b>Elizabeth Jeanne A. CARROLL</b>		2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 23 1979</b>		2b. HOUR <b>5:30</b>	
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec 17, 1929 49 YRS.</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 23 1979</b>	2d. HOUR <b>5:30</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Minnesota</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4803 Sheridan Street</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Law Firm</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Secretary</b>	
13a. STATE <b>Md</b>		13b. COUNTY <b>Pro Georges</b>	13c. CITY OR TOWN <b>Riverdale</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>4803 Sheridan Street</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Hjalner Gerard Alrick</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gladys Beers</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>			
16b. SOCIAL SECURITY NO. <b>579 46 9586</b>		17. INFORMANT <b>Helen A Barnes</b>		205 Delta Road <b>Knoxville, Tennessee</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon monoxide intoxication</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: <b>50A.P.M. 6 23 19 79 caught in housefire</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>4803 Sheridan St. Riverdale, Maryland</b>			
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				TITLE (SPECIFY) <b>Assistant</b>			
ACTUAL SIGNATURE <b>H.R. Guard</b>		M.D. <b>Assistant</b>		MEDICAL EXAMINER		DATE SIGNED <b>6/23/79</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>		ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>June 26, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pro Georges Md.</b>	
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sona P A Hyattsville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 28 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry Maloney</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>DENNIS D. CARVER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>06-24-79</b>			2b. HOUR <b>3:40AM</b>		
3 SEX <b>MALE</b>		4 RACE <b>BLACK</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>July 8, 1944</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>34</b> YRS.		7a. IF UNDER 1 YEAR MONTHS DAYS 7b. IF UNDER 24 HRS HOURS MIN.		
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b>		7d. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD.				
10 CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGES GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SKILLED LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GOV'T.</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>D. C.</b>					13b. COUNTY <b>WASHINGTON</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>5800 EAST CAPITOL STREET, N. E.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH B. CARVER</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>REGINA HAWKINS</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO (IF YES, GIVE YEAR OR DATES) <b>1963-1965</b>		17. INFORMANT ADDRESS <b>St. N. E. Wash. D.C.</b> <b>MRS. PEGGY E. CARVER/WIFE/5800 East Capitol</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiovascular arrest: shock</b> <b>5770</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>hemorrhagic pancreatitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>massive bleeding through GI tract</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>alcohol abuse</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6-23 (PM) 1979</b> to <b>6-24 (3:40) 1979</b> , that (I) (we) lost saw the deceased alive on <b>6-24 (3:40) 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>A Poorsektor</b>					DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6 26 79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Abbas Poorsektor</b>					22e. ADDRESS <b>P.G. Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>JUNE 30, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LANDOVER PG MARYLAND</b>			
24. FUNERAL DIRECTOR'S NAME <b>ROLLINS FUNERAL HOME, INC.</b> <b>4339 HUNT PLACE, N. E. WASH. D. C. 20019</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 2 1979</b>		25b. REGISTRAR'S SIGNATURE <b>History McCreedy</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 15460			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mabel J Clark				2a. DATE OF DEATH MONTH DAY YEAR 6-30-79			
3 SEX Female		4 RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR March 26, 1887		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 92 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10 CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY D.C. Public Sch	
13a. STATE D.C.				13b. COUNTY N/A		13c. CITY OR TOWN Washington	
14. FATHER'S NAME FIRST MIDDLE LAST Clinton Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown) Brown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No				16b. SOCIAL SECURITY NO. 577-62-0664T		17. INFORMANT ADDRESS Eugene Clark, son,	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver failure 1539 DUE TO, OR AS A CONSEQUENCE OF (b) Ca of colon - metastasis to the liver DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6-1-79, to 6-30-79, that (I) (we) last saw the deceased alive on 6-16-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)							
22b. SIGNATURE A. Tapera		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/30/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ATHANASIOS N. TAPERA				22e. ADDRESS 3012 18th St. N.E., WASH, DC			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 3, 1979		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME John + Bolder McGuire Funeral Service, Inc.				25a. DATE REC'D. BY REGISTRAR JUL 2 1979			
				25b. REGISTRAR'S SIGNATURE Fitzgerald			

Washington, D.C. 20012



U. S. A.

UNITED STATES OF AMERICA  
WASHINGTON, D. C. 20540





STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			7 15461				REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RONALD W. CLARK			2a. DATE OF DEATH MONTH DAY YEAR 06 09 79			2b. HOUR 7:45 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 9, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Police Officer		12b. KIND OF BUSINESS OR INDUSTRY House Guard	
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9014 Autoville Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Fred Clark			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle McKinnon			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes W.W.II			
17a. SOCIAL SECURITY NO. 008-14-0301			17. INFORMANT Jessie L. Clark			17b. ADDRESS Address Same as No # 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Hepatic Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiac Cirrhosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Heart Failure</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>5/21</i> 19 <i>79</i> to <i>6/9</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>6/8</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>W.L. Etienne</i> DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <i>6/9/79</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.L. ETIENNE						22e. ADDRESS College Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-12-79		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md.		
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Md.						25a. DATE REC'D. BY REGISTRAR JUN 14 1979		25b. REGISTRAR'S SIGNATURE <i>Trinity McCreedy</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of the retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 1 5 4 6 2 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) ELIZABETH - CLINK					2a. DATE OF DEATH MONTH DAY YEAR June 8, 1979			2b. HOUR 2.00 PM		
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Nov. 3, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George Co. MD.				
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital of Pr. Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None		
13a. STATE Maryland					13b. COUNTY Pri. Geo.		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME (unknown)					15. MOTHER'S MAIDEN NAME Esther (unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Mary Gwyn, 6600 Cipriano Rd., Lanham, Md.						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-pulmonary arrest</u> 586- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septic Shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Arteriosclerosis Heart Disease; Diabetes Mellitus; Hypertension</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from <u>1970</u> , 19 <u>  </u> , to <u>6-8</u> , 19 <u>79</u> , that (1) (we) last saw the deceased alive on <u>6-8</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE David Schachter				DEGREE O.O.				22c. DATE SIGNED 6-8-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID Schachter				22e. ADDRESS 115 Century, Greenbelt, Md 20770						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 12, 1979		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Leckrone, Penna.				
24. FUNERAL DIRECTOR Robert G. Beall Funeral Home 9013 Annapolis Road, Lanham, Maryland				25a. DATE REC'D. BY REGISTRAR JUN 12 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy				

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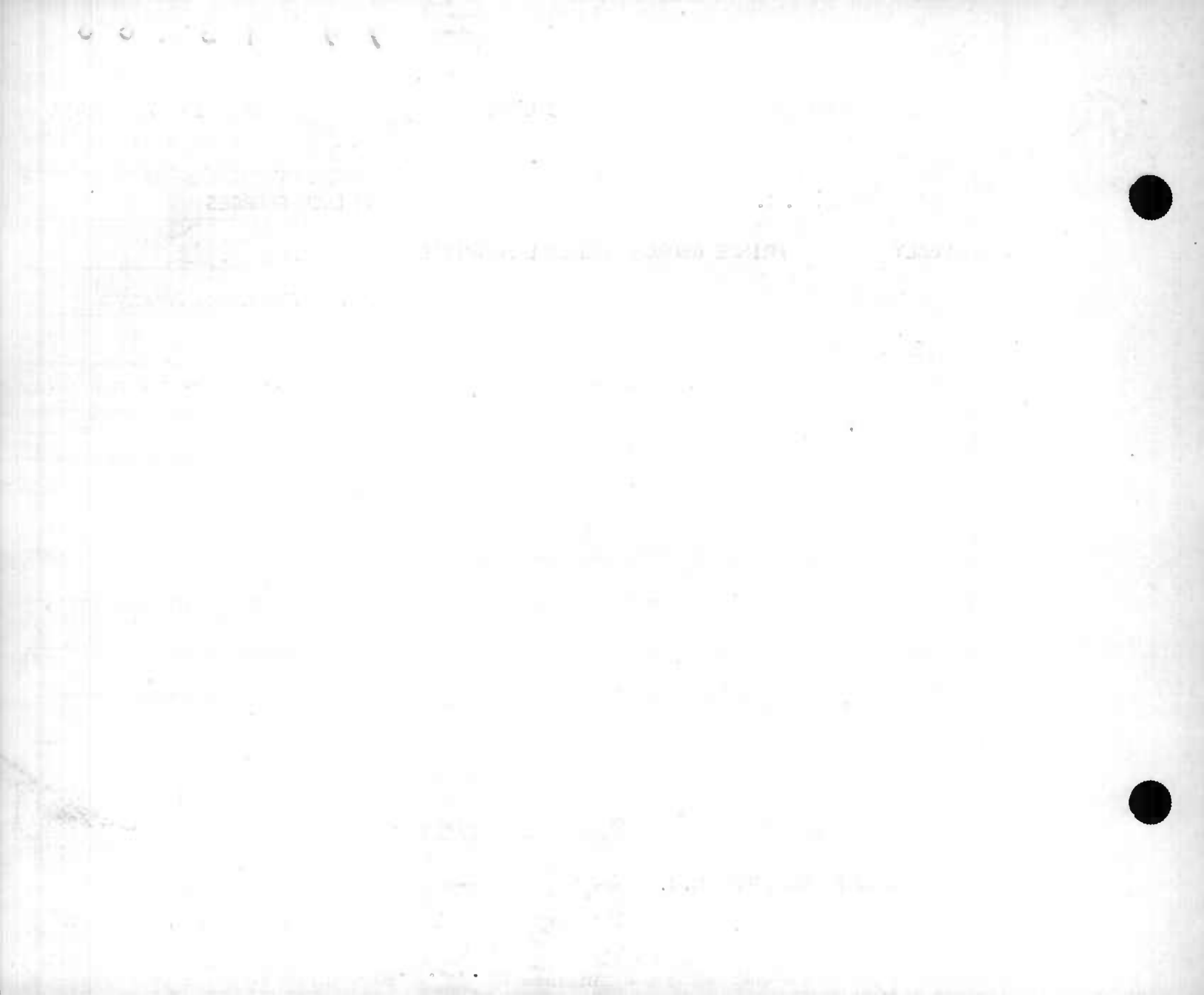
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 15463						
1. DECEASED NAME (TYPE OR PRINT) <b>HOWARD COLEMAN</b>			2a. DATE OF DEATH MONTH <b>06</b> DAY <b>29</b> YEAR <b>79</b>			2b. HOUR <b>4:45A M</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>Feb.</b> DAY <b>9</b> YEAR <b>1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGES</b> MD.			
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGES GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Glen Arden</b>			13c. CITY OR TOWN <b>Glen Arden</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7915 Johnson Avenue</b>		
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>Coleman</b> LAST <b></b>			15. MOTHER'S MAIDEN NAME FIRST <b>unknown</b> MIDDLE <b></b> LAST <b></b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>578 12 9755</b>		17. INFORMANT ADDRESS <b>Mrs. Anna Coleman-wife-7915 Johnson Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coma</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Carcinoma to Brain</b> (c) <b>Cancer of Lung</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Liver Metastases</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/19</b> , 19 <b>79</b> , to <b>6/29</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/29</b> , 19 <b>79</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <b>Robert Ruderman</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6/29/79</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT RUDERMAN M.D.</b>				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/7/79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>		23d. LOCATION CITY OR TOWN <b>Landover</b> COUNTY <b>Maryland</b> STATE <b></b>			
24. FUNERAL DIRECTOR NAME <b>Stewart Funeral Home</b> ADDRESS <b>4001 Benning Rd., N.E.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 9 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Lillian McCready</b>			



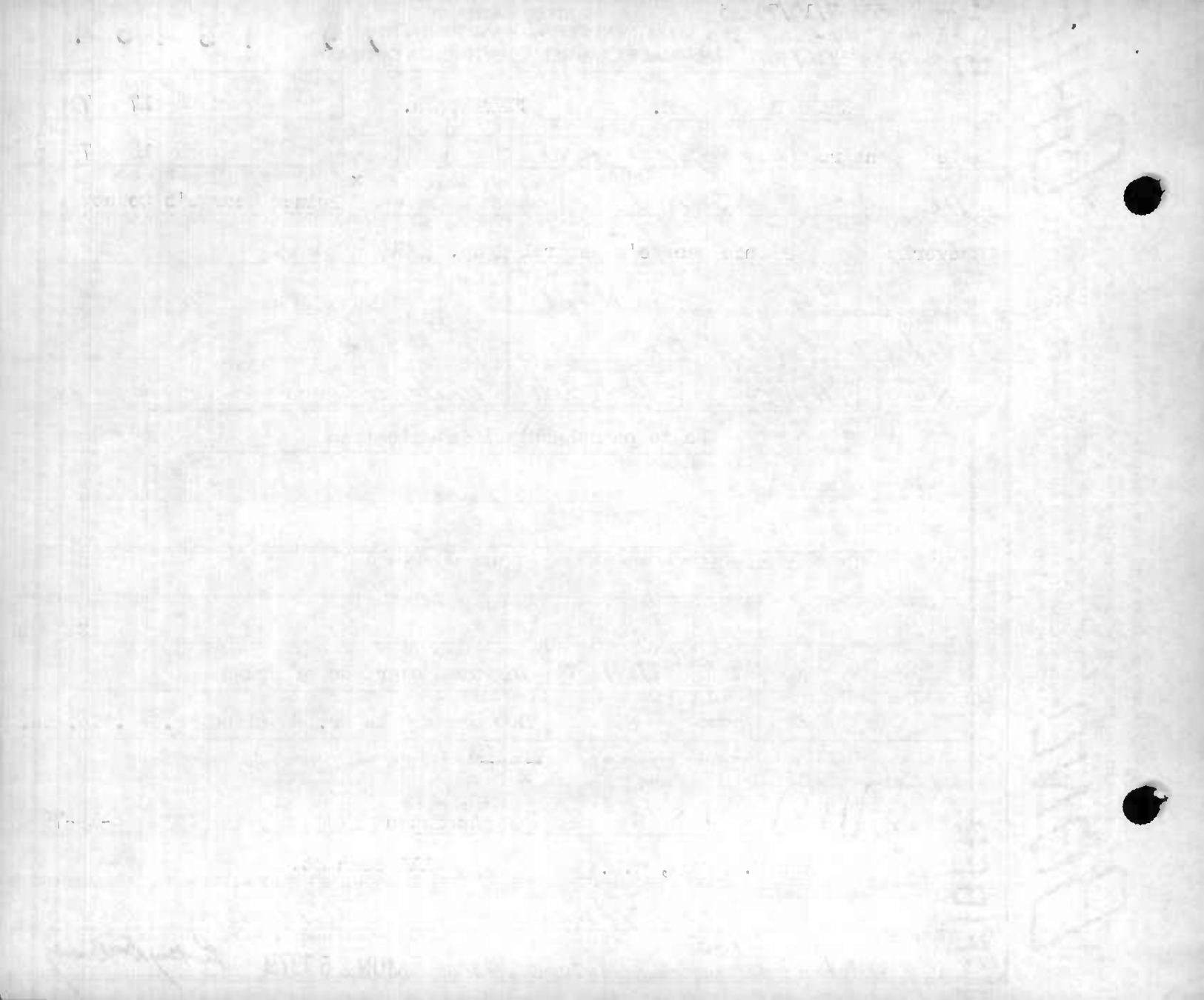


Item 8 8533 7/10/79 g3  
FOR Items "18a-22a Film DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
1- STATE REGISTRAR G533 7/16/79 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 15464  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES E. CONTEE, JR.</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 17 19 79</b>			2b. HOUR M <b>1:08</b> P M
3. SEX <b>male</b>	4. RACE <b>negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 30, 1951</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>28</b> YRS.	IF UNDER 1 YR. MONTHS DAYS <b>28</b>	IF UNDER 24 HRS. HOURS MIN. <b>28</b>	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 18 19 79</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County</b> MD.
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George's General Hosp. (DOA)</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>P.G.</b>	13c. CITY OR TOWN <b>Suitland</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>3000 Great Oaks Dr.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles E Contee Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth Linton</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT ADDRESS <b>Charles E Contee Sr Samuels 9D</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Acute phenobarbital intoxication</b> IMMEDIATE CAUSE (a) <b>9501</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8 17 19 79</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Ingested overdose of drugs</b>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3000 Great Oaks Dr. Suitland Pr. Geo. Co. Md.</b>		
22a. I certify that I took charge of the remains described above, held on <b>Autopsy</b> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <b>Ann M. Dixon</b>		TITLE (SPECIFY) <b>Assistant</b>		MEDICAL EXAMINER		DATE SIGNED <b>6-19-79</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>		ADDRESS <b>111 Penn St.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>6-21-79</b>		23b. DATE <b>6-21-79</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Highland Pr. Md</b>
24. FUNERAL DIRECTOR NAME <b>U.S. Washington &amp; Sons Nannell Bunnell &amp; Co.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 25 1979</b>		25b. REGISTRAR'S SIGNATURE <b>Henry M. Brady</b>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FOLDED, WITH THE "PENDING" AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 15465	
1. FOR STATE REGISTRAR										20. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Donald R. Crane										ESTIMATED <input checked="" type="checkbox"/> June 5 1979	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6-3-15 64 YRS.	6. AGE (IN YEARS) LAST BIRTH (BOAT)	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD 6-14 1979	2d. HOUR				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's			MD.		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Army		12b. KIND OF BUSINESS OR INDUSTRY Military-Ret.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. CITY OR TOWN Pr. George's		13c. CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 6350 Maxwell Drive					
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Crane				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucille Comb							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII - Korea		17. INFORMANT 375-12-9670		6305 Shirley Drive Barbalou C. Foley Ft. Worth, Texas					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiac vascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>August P. Rodriguez</i>		M.D. <i>July</i>		MEDICAL EXAMINER				DATE SIGNED 6-15-79			
EXAMINER'S NAME (TYPE OR PRINT) August P. Rodriguez		ADDRESS 5009 Rayburn Ct., Camp Springs Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/19/79		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia			
24. FUNERAL DIRECTOR NAME ADDRESS George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md.				25a. DATE REC'D. BY REGISTRAR JUN 19 1979		25b. REGISTRAR'S SIGNATURE <i>Anthony McCready</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARGARET MITCHESON DAY</b>			2a. DATE OF DEATH MONTH <b>6</b> DAY <b>12</b> YEAR <b>79</b>		2b. HOUR M
3. SEX <b>FEMALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>June</b> DAY <b>21</b> YEAR <b>1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Laurel</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>12401 Silverbirch Lane</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		
13a. STATE <b>Md</b>			13b. COUNTY <b>PG</b>	13c. CITY OR TOWN <b>Laurel</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <b>Whitney J.</b> MIDDLE <b>Aitcheson</b> LAST			15. MOTHER'S MAIDEN NAME FIRST <b>Lina</b> MIDDLE <b>Bowdoin</b> LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214 30 0785</b>		17. INFORMANT ADDRESS <b>Franklin R. Day same as 13 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1749</b> IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b> 1974 DUE TO, OR AS A CONSEQUENCE OF (b) <b>BREAST CARCINOMA</b> 1972 DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1938</b> 19 to <b>6/12/79</b> 19, that (I) (we) last saw the deceased alive on <b>6/11/79</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>J.M. Warren</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J.M. WARREN</b>				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 15, 1979</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem</b>	
23d. LOCATION CITY <b>Arlington</b> COUNTY <b>Va</b> STATE		25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1979</b>			
24. FUNERAL DIRECTOR NAME <b>Donaldson Funeral Home, Laurel, Md</b> ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Dorothy McCreedy</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

79 15467

1 DECEASED NAME (TYPE OR PRINT) <b>SADIE</b>			MIDDLE <b>R.</b>			LAST <b>DeANGELIS</b>			2a DATE OF DEATH MONTH DAY YEAR <b>6 29 79</b>			2b HOUR <b>1:30 AM</b>		
3 SEX <b>FEMALE</b>			4 RACE <b>White</b>			5 DATE OF BIRTH MONTH DAY YEAR <b>5 27 1891</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>88</b>			7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>88</b> YRS		
8a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S</b> MD					
10 CITY OR TOWN OF DEATH <b>CLINTON</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>150 M.D. Hosp CENTER</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>			12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>M.D.</b>			13b COUNTY <b>Baltimore</b>			13c CITY OR TOWN <b>Parkville</b>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS <b>1912 Redwood Avenue</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Joseph</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna</b>											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO. <b>218-05-272866</b>			17 INFORMANT ADDRESS <b>Mrs. Florence Murphy 1912 Redwood Avenue</b>								
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myelogenous Leukemia.</b> 2051 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Myelogenous Leukemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>24 mo.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 mo.</b>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that (I) (this hospital) attended the deceased from <b>6-25</b> 19 <b>79</b> to <b>6-28</b> 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6-28</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE <b>E. W. West</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <b>6-29-79</b>					
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edwin E. West, M.D.</b>			22e ADDRESS <b>Indian Head Hwy. Oxen Hill, Maryland.</b>											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>7-2-1979</b>			23c NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>			23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>					
24 FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b>			ADDRESS <b>5305 Harford Rd. Balto; Md.</b>			25a DATE REC'D. BY REGISTRAR <b>JUL 2 1979</b>			25b REGISTRAR'S SIGNATURE <b>Barry McBrady</b>					

BP







STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 15468	
1. FOR STATE REGISTRAR										2a. DATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rose A. Dillon										MONTH DAY YEAR 6-22-79	
3 SEX female										2b. HOUR 8:20 AM	
4 RACE white										5. DATE OF BIRTH MONTH DAY YEAR 1 21 1896	
6 AGE (IN YEARS LAST BIRTHDAY) 83										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York										7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9 BALTIMORE CITY OR COUNTY OF DEATH Pr. Geo.	
10 CITY OR TOWN OF DEATH Hyattsville										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Manor	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife										12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Md.										13b. CITY OR TOWN Hyattsville	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13d. STREET ADDRESS 2111 - Ingraham St.	
14. FATHER'S NAME FIRST MIDDLE LAST Patrick, Mullen										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Sweeney	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 577-62-0626	
17 INFORMANT ADDRESS James E. Dillon (same as above)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 4240 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Mitral insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days, 3 15 yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION -											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -											
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19											
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)											
21f. LOCATION CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 6/21/79, to 6/22/79, that (I) (we) last saw the deceased alive on 6/21/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did) (did not) view the body after death.											
22b. SIGNATURE R. C. KIRCHNER M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22c. DATE SIGNED 6/22/79											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. C. KIRCHNER MD											
22e. ADDRESS 6480 N.H. Ave Takoma Park MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial											
23b. DATE 6/25/1979											
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.											
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Geo. Md.											
24. FUNERAL DIRECTOR Nalley's F.H. Inc. ADDRESS Mt. Rainier, Md.											
25a. DATE REC'D. BY REGISTRAR JUN 28 1979											
25b. REGISTRAR'S SIGNATURE Henry McCurdy											

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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U.S.A.

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Mr. J. Edgar Hoover

Director

Director

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15469

1. DECEASED NAME (TYPE OR PRINT) IDA L. DION			2a. DATE OF DEATH MONTH DAY YEAR 06 11 79		2b. HOUR 8:08 P.M.
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 15, 1892		6 AGE (IN YEARS LAST BIRTHDAY) 87	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY, MD.		
10. CITY OR TOWN OF DEATH LAUREL, MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL, BELTSVILLE HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY P.G. Co.	13c. CITY OR TOWN Laurel	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Nelson Beaudin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melina Young		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-48-6369		17. INFORMANT ADDRESS Pauline D. Davies same as #B3	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY ARTERY DISEASE</u> 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CONGESTIVE HEART FAILURE</u> (c) <u>CEREBRO VASCULAR ACCIDENT</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6. 9</u> 19 <u>79</u> , to <u>6. 11</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6. 11</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE VPSingh		DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIRENDER P. SINGH		22e. ADDRESS EAST WEST HIGHWAY 3700 HYATTSVILLE MD. 20782			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/14/79	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR FLECK LAUREL FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20810		25a. DATE REC'D. BY REGISTRAR JUN 13 1979		25b. REGISTRAR'S SIGNATURE Fitzpatrick	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

9

15470

REG. NO.

1. FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
ISIDORO		LORENZO	DOMINGO		06		13	79	10:56A.M.		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Caucasian		01 01 04		75		MONTHS		DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Phillipines		U.S.A.				Prince Georges MD					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Clinton		Southern Maryland Hospital Center				Retired		Rail Road			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Md.		Charles		Waldorf		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6009 Suzanna Rd.			
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS	
Unknown		Unknown		No		None		Gladys Quimado		Same As #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPSIS AND RENAL FAILURE											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY INFECTION											
DUE TO, OR AS A CONSEQUENCE OF (c) RESPIRATORY FAILURE											
DUE TO, OR AS A CONSEQUENCE OF CEREBROVASCULAR ACCIDENT											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
HYPERTENSIVE CARDIOVASCULAR DISEASE											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 3-27 1979 to 6-13 1979, that (I) (we) lost saw the deceased alive on 6-13 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		DEGREE				22c DATE SIGNED					
DANILLO G. LEE, MD		6192 OXON HILL RD OXON HILL, MD 20021				6-13-79					
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS				22f DATE SIGNED		22g REGISTRAR'S SIGNATURE			
DANILLO G. LEE, MD		6192 OXON HILL RD OXON HILL, MD 20021				JUN 18 1979		L. J. McCreedy			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE		23e DATE REC'D. BY REGISTRAR			
Burial		6/16/79		Ft. Lincoln Cemetery		Brentwood, P.G. Md.		JUN 18 1979			
24 FUNERAL DIRECTOR'S NAME		24b ADDRESS				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Lee Funeral Home Inc.		6633 Old Alexander Ferry Rd. Clinton, Md.				JUN 18 1979		L. J. McCreedy			

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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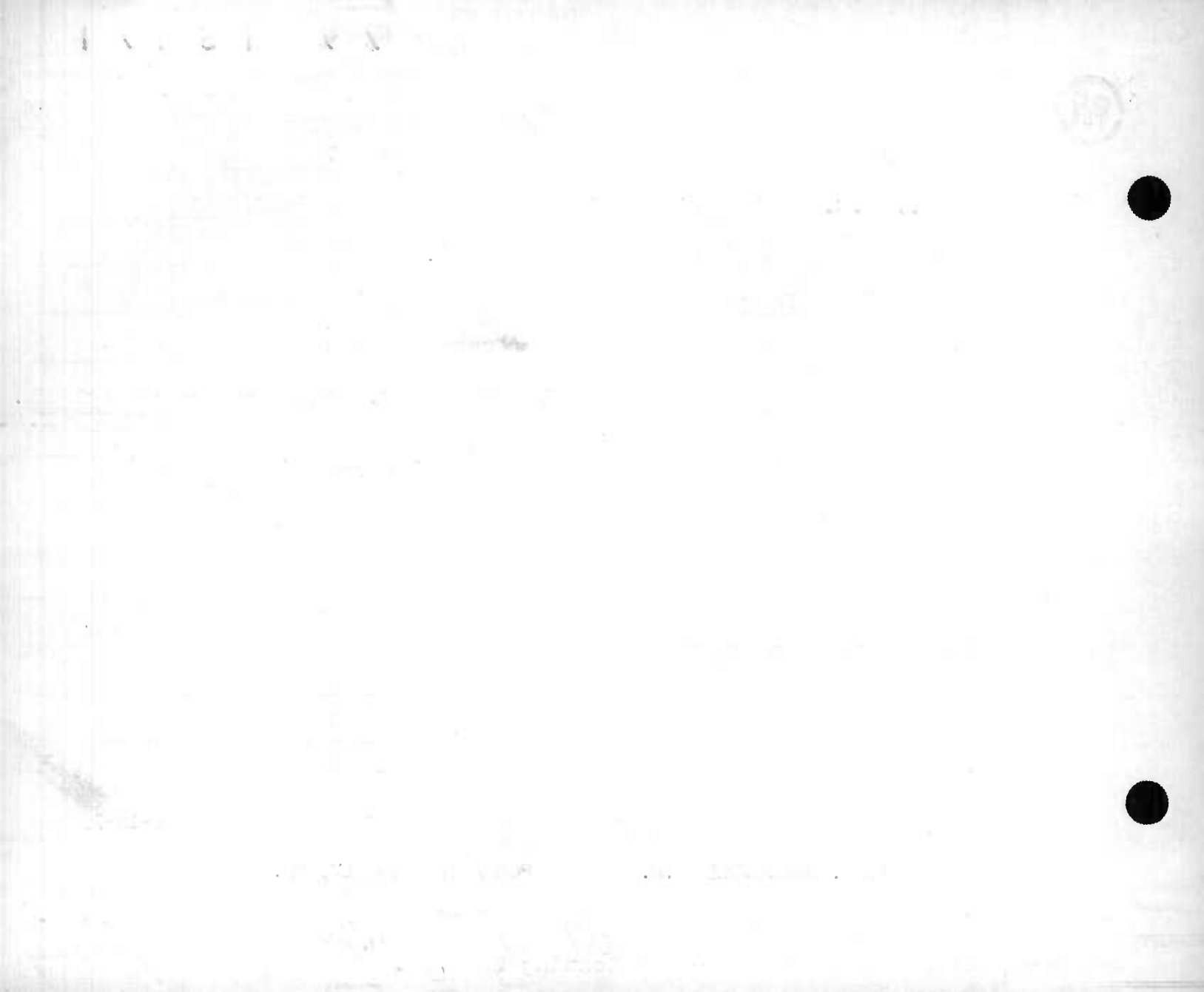


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |  |
|---|--|--|--|---|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  | 7 9 15471<br>REG. NO.  |   |  |  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>LELIA T. DOUGLAS</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>06-12-79</b>                 |   |  |  | 2b. HOUR<br><b>6:40 AM</b>   |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 20 1900</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS. MONTHS DAYS<br><b>79</b>                   |  | 7. IF UNDER 1 YEAR<br>IF UNDER 24 HRS<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash., D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>PRINCE GEORGE'S</b> MD.                 |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CHEVERLY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PRINCE GEORGE'S GENERAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                   |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Largo</b>  |   | 13c. CITY OR TOWN<br><b>PG</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>611 Pearse Lane</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Hamlet Dozier</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah Welford</b>   |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>578 68 2322</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>Richard C. Douglas-son-4903 7th Pl.</b>         |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>410-</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Acute myocardial infarction</b><br>(c) <b>Due to, or as a consequence of</b> |  |  |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1.5</b>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-7</b> 19 <b>79</b> , to <b>6-12</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6-12</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Hernandez</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><b>6-12-79</b>                  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>TOMAS J. HERNANDEZ M.D.</b>   |  |  |  |   | 22e. ADDRESS<br><b>PGGH/MC, CHEVERLY, MD.</b>                                  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, RECEPTIONAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>6/18/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cemetery Arlington, Va.</b>         |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Stewart Funeral Home-4001 Benning Road, NE.</b>  |  |  |  |   | 25a. DATE WHEN BY REGISTRAR<br><b>JUN 18 1979</b>                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>                                 |   |  |  |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15472

|   |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
|---|--|---|--|--|--|---|--|---|--|--------------------------------|--|---|--|--------------|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 6 17 19 79 |  |  |  |   |  |   |  |                                |  | 2b. HOUR 12 M   |  |              |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE   |  | LAST  |  | 2c. DATE PRONOUNCED DEAD 6 17 19 79   |  |                                |  |   |  | 24 HOUR NOON |  |
| Julia Elizabeth Dove  |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)                                  |  | IF UNDER 1 YR.<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |   |  |              |  |
| Female  |  | White   |  | 6 10 06  |  | 73 YRS.   |  |   |  |                                |  |   |  |              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                                |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |              |  |
| Maryland  |  |   |  | USA  |  |   |  |   |  |                                |  | Prince George's County, MD.   |  |              |  |
| 10. CITY OR TOWN OF DEATH   |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  |                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |              |  |
| Camp Springs  |  |   |  | 6425 Allentown Rd.   |  |   |  |   |  |                                |  | Retired   |  |              |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| Drug Store  |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS   |  |                                |  |   |  |              |  |
| Md.   |  | Pr. Geo.  |  | Camp Springs   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 6425 Allentown Rd.  |  |                                |  |   |  |              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST   |  |                                |  |   |  |              |  |
| John Lee Biggs  |  |   |  |  |  |   |  | Elizabeth Schroath  |  |                                |  |   |  |              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |  |   |  | 16b. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT   |  |                                |  | ADDRESS   |  |              |  |
| no  |  |   |  | none   |  |   |  | 577-03-1698A  |  |                                |  | Rosie Biggs same as item 13   |  |              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| PART I DEATH WAS CAUSED BY:   |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u>  |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| (b) _____   |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| (c) _____   |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |   |  |                                |  | 20. AUTOPSY?  |  |              |  |
|   |  |   |  |  |  |   |  |   |  |                                |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |              |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |                                |  |   |  |              |  |
|   |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |                                |  |   |  |              |  |
|   |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| TITLE (SPECIFY)   |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| Assistant MEDICAL EXAMINER  |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| DATE SIGNED 6/18/79   |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| ACTUAL SIGNATURE <u>Margarita A. Korell</u> M.D.  |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn St. Balto., MD.  |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |   |  | 23b. DATE  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |              |  |
| Burial  |  |   |  | 6/20/79  |  |   |  | Cedar Hill Cemetery   |  |                                |  | Suitland Md.  |  |              |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS  |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| George P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.   |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |
| JUN 19 1979 <u>Richard M. Bailey</u>  |  |   |  |  |  |   |  |   |  |                                |  |   |  |              |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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## Discussion

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*Abstract* In this paper we discuss the

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15473

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |   |  |  |   |  |  |
|--|--|---|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MARCELLA D. DRAPP</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>6</b> DAY <b>2</b> YEAR <b>79</b>        |   |  | 2b. HOUR<br><b>5:30 p.m.</b>  |  |  |   |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>CAUC</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>2</b> YEAR <b>04</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |   | 7. IF UNDER 24 HRS<br>HOURS <b>0</b> MIN <b>0</b>            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>PRINCE GEORGE'S</b> MD                               |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CLINTON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTHERN MD HOSPITAL CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                                    |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. CITY OR TOWN <b>Charles</b> 13c. CITY OR TOWN <b>BRYANTOWN</b>   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>LOT 3 PO BOX 249 BRIAR RIDGE RD.</b>                                  |  |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>William C.</b> MIDDLE <b>Bachman</b> LAST <b>Charles</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Agnes</b> MIDDLE <b>Roach</b> LAST <b>Charles</b>  |  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>578-20-8064</b>  |  | 17. INFORMANT<br>ADDRESS <b>P.O. BOX 249 Lot 3</b><br><b>Matthew A. Drapp Brantown Maryland</b> |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>MALIGNANT LYMPHOMA, MIXED CELL TYPE</b><br><b>2008</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 28, 1978</b> , to <b>JUNE 2, 1979</b> , that (we) lost saw the deceased alive on <b>JUNE 2, 1979</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)   |  |   |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>James G. Brown MD</b>   |  |   |  |   |  | DEGREE<br><b>MD</b>   |  |  | 22c. DATE SIGNED<br><b>6/3/79</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES A. BROWN MD</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>6525 BEACREST RD HYATTSVILLE, MD 20782</b>                                   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |   | 23b. DATE<br><b>6/6/79</b>   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Church Cem.</b>                             |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Bryantown</b> COUNTY <b>Chal.</b> STATE <b>MD.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Lee Funeral Home Inc.</b> ADDRESS <b>6683 Old Alexander Ferry Rd. Clinton, Maryland</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 8 1979</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Dorothy McCreedy</b>                               |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 79   |  | 15474  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>ROBERT EDWARD DYSON  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>6 4 79   |  | 2b. HOUR<br>2:35P.M.   |  |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>BLACK   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 8 93  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>86 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASH, D.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGE'S MD                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>CLINTON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>SOUTHERN MARYLAND HOSPITAL |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>UNKNOWN                     |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>D.C.   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>WASHINGTON  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>1003 HOWARD ROAD, S.E.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JOHN DYSON  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>LUCY FRAZIER   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>577 12 9022  |  | 17. INFORMANT ADDRESS<br>2605 M.E. KING AVE, D.C.<br>JAMES H. RABY, ESQUIRE  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ASHD</u><br>Years |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Minutes   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6</u> 19 <u>78</u> to <u>6/4</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/4</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                              |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE <u>CF Glos</u>  |  |  |  | DEGREE   |  |  |  | 22c. DATE SIGNED<br>6/4/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHARLES F. COLAO  |  |  |  | 22e. ADDRESS<br>3710 RIVIERA ST., MARLOW HEIGHTS MD. 20637   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>6/7/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LINCOLN MEM. CEM.  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>SUITLAND, MARYLAND MD. 20637                      |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>ROBERT G. MASON FUNERAL HOME, INC.<br>1661 GOOD HOPE RD., S.E.<br>WASHINGTON, D.C. 20020  |  |  |  | 25. DATE RECD. BY REGISTRAR 25b. REGISTRAR<br>JUN 7 1979   |  |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND Items 21a. - 21f. & 22a.  |  |   |  |   |  |   |  |  |  |   |
|---|--|---|--|---|--|---|--|--|--|---|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  |   |  |   |  |  |  |   |
| CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |   |
| REG. NO.  |  |   |  |   |  |   |  |  |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CLAYTON JOSEPH ECKARD</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH <b>06</b> DAY <b>21</b> YEAR <b>79</b>          |   |  |  |  | 2b. HOUR<br><b>5:40p M</b>  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>20</b> YEAR <b>1912</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS <b>06</b> DAYS <b>21</b>  |  | 7. IF UNDER 24 HRS.<br>HOURS <b>5</b> MIN. <b>40</b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges County MD</b>                         |  |  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Clinton</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTHERN MARYLAND HOSPITAL CENTER</b> |  |   |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MALE)<br><b>Retired</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steam Fitter</b> |   |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Prin Geo.</b>   |  | 13c. CITY OR TOWN<br><b>Brandywine</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>20613 13702 Old Brandywine Rd</b>  |  |   |
| 14. FATHER'S NAME<br>FIRST <b>Israel</b> MIDDLE <b>Eckard</b> LAST  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Carrie</b> MIDDLE <b>Simmons</b> LAST |   |  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW11</b>  |  | 17. INFORMANT<br><b>Mary E. Eckard</b>  |  | 17. ADDRESS<br><b>Same as #13</b>   |  |  |  |   |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4589</b> IMMEDIATE CAUSE (a) <b>Shock due to hypertension</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>renal shut down</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>Chronic Spinal Cord Injury.</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Injury.</b><br>(c) _____ |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |   |  |   |  |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5:20 P.M. 5 14 79</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>Fall at Home</b>   |  |   |  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>home</b>   |  | 21f. LOCATION<br>STREET<br><b>Brandywine</b>  |  | CITY OR TOWN<br><b>P.G.</b>   |  | COUNTY<br><b>Md.</b>   |  | STATE   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/21/79</b> to <b>6/21/79</b> , that (I) (we) last saw the deceased alive on <b>6/21/79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <b>Natural</b>   |  |   |  |   |  |   |  |  |  |   |
| 22b. SIGNATURE<br><b>MOASSER MD</b>   |  |   |  |   | 22c. DEGREE<br><b>MD</b>   |   |  | 22d. DATE SIGNED<br><b>6/29/79</b>   |  | 22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Moasser</b>   |  |   |  |   | 22g. ADDRESS   |   |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>6/25/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Trinity Memorial</b>   |  | 23d. LOCATION<br>CITY OR TOWN<br><b>Gar Waldorf</b>   |  | COUNTY<br><b>Charles</b>   |  | STATE<br><b>Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME <b>George Funeral Home Inc.</b><br>ADDRESS <b>6633 Old Alexander Ferry Rd. Clinton, Md.</b>  |  |   |  |   | 25a. DATE RECEIVED BY REGISTRAR<br><b>JUN 28 1979</b>                      |   | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCready</b>                |  |  |   |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 9 15476  |   |
|--|--|---|--|--|---|
| 1 - FOR<br>STATE<br>REGISTRAR  |  |   |  | REG. NO.   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edmond Forrest Edwards</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6-16-79</b>                                      |  | 2b. HOUR<br><b>6:35<sup>P</sup></b>                           |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>white</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov 16, 1907</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b><br>YRS. MONTHS DAYS HOURS MIN.                            |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Va</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Pro Georges County</b> MD.                                  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pro Georges General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Holtier Retired</b> |  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <b>Md</b> 13c. COUNTY <b>Pro Georges</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   | 13e. STREET ADDRESS<br><b>4090 Warner ave Apt D 6</b>                                      |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ernest Edwards</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lilly Adams</b>                        |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>719 03 1720</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Lydia C Edwards Landover Hills, Md.</b>                                 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>AORTIC VALVULAR STENOSIS</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CORONARY HEART DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(c) <b>ATRIAL FIBRILLATION</b> |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 HOUR</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                         |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-17-79</b> to <b>6-16-79</b> , that (I) <del>lost</del> saw the deceased alive on <b>5-17-79</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>viewed</del> (did not) view the body after death.                                       |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Lawrence Satin MD</b> DEGREE  |  |   |  | 22c. DATE SIGNED<br><b>6-18-79</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lawrence Satin</b>   |  |   |  | 22e. ADDRESS<br><b>Riverdale, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>June 19, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Brentwood Pro Georges Cemetery</b>                            |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>F. Gasch's Sons</b>   |  | ADDRESS<br><b>P A Hyattsville, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>JUN 19 1979</b> <i>Barney MacCreedy</i> |   |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |   |   | 7 9 15477                   |  |
|---|--|--|--|--|---|--|--|---|---|-----------------------------|--|
| 1. FOR STATE REGISTRAR  |  |  | REG. NO.   |  |   |  |  |   |   |                             |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Rose</b>   |  |  | FIRST MIDDLE LAST<br><b>EPSTEIN</b>                                    |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>6/10/79</b>   |  |   | 2b. HOUR<br><b>74</b> M   |                             |  |
| 3 SEX<br><b>F</b>   |  | 4 RACE<br><b>W.</b>  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>5 21 09</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS   |   | IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges</b> MD.  |  |   |   |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Greenbelt</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6231 Springhill Drive</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                              |   |                             |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>P. Georges</b>                                       |  | 13c. CITY OR TOWN<br><b>Greenbelt</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>6231 Springhill Drive</b>   |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Max Fuchs</b>   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Annie Berger</b>      |  |   |  |  |   |   |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>Unknown</b> |  | 17. INFORMANT ADDRESS<br><b>Maryland</b><br><b>Moe Epstein, 6231 Springhill Dr., Greenbelt,</b> |  |  |   |   |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br><b>1749</b> IMMEDIATE CAUSE (a) <b>Adequately of Breast</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1475</b> |  |  |  |  |   |  |  |   |   |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |   |  |  |   |   |                             |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |   |   |                             |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/10</b> 19 <b>79</b> , to <b>6/10</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>5/10</b> 19 <b>79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |   |  |  |   |   |                             |  |
| 22b. SIGNATURE<br><b>S. H. Levin</b>  |  |  | DEGREE   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>6/10/79</b>  |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Edgar H. Levin</b>  |  |  |  |  | 22e. ADDRESS<br><b>8630 Fenton Street, Silver Spring, Md.</b>                                   |  |  |   |   |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>6-12-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Judean Mem. Gardens</b>                                |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Olney, Montgomery, Maryland</b> |   |                             |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Danzansky-Goldberg Mem. Chap. Rockville, Md.</b>  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 14 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |   |                             |  |

MEDICAL CERTIFICATION

11.01.81

STANDARD FORM NO. 64



30 10/10/81 10/10/81 10/10/81

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10/10/81

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |   |  |  |  |  |
|---|--|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Anne Temple Faass</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>6 26 79</i>                  |  |   | 2b. HOUR<br><i>3:30A.M.</i>  |  |  |  |
| 3 SEX<br><i>FEMALE</i>  |  | 4 RACE<br><i>Caucasian</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>oct. 21 1898</i>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>YRS<br><i>80</i>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>New Hampshire</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Prince George</i> MD.  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><i>Seabrook</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>6812 96th Place</i> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Pr. Geo.</i>  |  | 13c. CITY OR TOWN<br><i>Greenbelt</i>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><i>6204 Springhill Drive #303</i>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>John P. Temple</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Elizabeth Sweeney</i>  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><i>214-32-7786</i>  |   | 17 INFORMANT <i>son</i><br>ADDRESS <i>6812 96th Place</i><br><i>Seabrook, Maryland</i>   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>CACHEXIA</i><br><i>1590</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <i>OBSTRUCTION OF BOWEL.</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>TERMINAL CARCINOMA OF BOWEL</i> |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>3 months</i><br><i>1 + yrs.</i>   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>           |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>JAN</i> 19 <i>79</i> , to <i>6-26</i> 19 <i>79</i> , that (1) (we) lost <i>now the deceased alive</i> <i>MAY</i> 19 <i>79</i> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.  |  |   |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><i>Robert Ruderman M.D.</i>   |  |   |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>6/26/79</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Robert Ruderman M.D.</i>  |  |   |  |  |   | 22e. ADDRESS<br><i>6201 GREENBELT RD. COLLEGE PARK, Md.</i>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  |   | 23b. DATE<br><i>Jun. 29, 1979</i>                                      |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Resurrection</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Clinton Pr. Geo. Maryland</i> |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><i>Francis J. Collins</i>  |  |   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 29 1979</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony McBrady</i>   |  |

6. 1. 2. 3. 4. 5. 6.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH15479  
REG. NO.1- FOR  
STATE  
REGISTRAR

|  |                         |   |  |   |   |  |
|--|-------------------------|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Earcel Lee Faircloth</b>   |                         |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>6 27 19 79</b> |   |   | 2b. HOUR<br>M<br><b>11:30 P.M.</b>   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 1, 1958</b>   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>21 YRS.</b>   | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>6 27 19 79</b> | 7d. HOUR<br>P.M.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. Carolina</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                     |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's County, MD.</b>           |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Prince George's General Hospital (DOA)</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Truck Driver</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>Florida</b>   |                         | 13b. COUNTY<br><b>Sanford</b>   |  | 13c. CITY OR TOWN<br><b>Sanford</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Elwood Faircloth</b>  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Martha Gist</b>   |  | 16. STREET ADDRESS<br><b>32771 3681 State Rd 46 W. Sanford Fla</b>  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |                         | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Drowning</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br><b>8120</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |                         |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |                         |   |  |   |   |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR XX MONTH DAY YEAR<br><b>6:15 P.M. 6 27 19 79</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Driver of tractor-trailer hit auto, traversed bridge guard rail, and dropped into water</b> |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>bridge</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Rt. 495, Woodrow Wilson Bridge, Prince George's, Md.</b>  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |  |   |   |  |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>   |                         | M.D. <b>Assistant</b>   |  | MEDICAL EXAMINER  |   | DATE SIGNED <b>6/29/79</b>   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>   |                         | ADDRESS<br><b>111 Penn Street</b>   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>July 2, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hollygrove Cem</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Clinton N. Carolina</b>             |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Harry H. Witzke Columbia R Ellicott City</b>  |                         |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 5 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                     |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE MAILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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John's been



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15480

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Virginia P. Farr  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6-14-79 |   |  | 2b. HOUR<br>8:10 P. M.  |  |
| 3. SEX<br>F  |  | 4. RACE<br>Negro   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 31 90   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Virginia |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PG County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Adelphi                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ManorCare Adelphi |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Home maker  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>PG County   |  | 13c. CITY OR TOWN<br>Fairmont Heights   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS<br>1019 58th Ave.                    |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>RICHARD RATCLIFFE  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ETTA HORTON  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO                       |  |
| 16a. SOCIAL SECURITY NO.<br>229-32-8353                  |  | 17. INFORMANT<br>JOHN J. FARR, JR.   |  | 17. ADDRESS<br>42 31 EADS ST. N.E.<br>WASHINGTON, D.C. 20019  |  |   |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Terminal Cerebral Neoplasm</u><br>4340<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>—</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>—</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>Years <u>—</u> |  |
|--|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/11/78</u> 19 <u>—</u> to <u>6/14/79</u> 19 <u>—</u> , that (I) (we) lost<br>saw the deceased alive on <u>6/12/79</u> 19 <u>—</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>   |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>6/14/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>OSOOTH  |  | 22e. ADDRESS<br>LEKAGUL MD 7425 Arlington Rd, Bethesda, MD             |  |  |  |   |  |

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL |  | 23b. DATE<br>6-18-79                       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>FARR Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CENTREVILLE VA 22020 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Bernard O. Ames        |  | ADDRESS<br>8914 QUARRY RD<br>MANASSAS, VA. |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 19 1979        |  | 25b. REGISTRAR'S SIGNATURE<br>Anthony K. Brady                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



*[Faint, mostly illegible text on lined paper, possibly a letter or report.]*

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 15481   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>LILLIAN A. FIGGINS</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 11 79</b>   |  | 2b. HOUR<br><b>5:30P.M.</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4-12-1920</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Pr. Geo.</b> MD.                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>RIVERDALE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>LELAND MEMORIAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Window Cleaner</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |   |  |  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Pr. Geo.</b>   |  | 13c. CITY OR TOWN<br><b>Mt. Rainier</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3702 - 35th Street</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lewis Talbot</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Shiflett</b> |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No -</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>224-32-1283</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Same As John W. Figgins (Husband) Above</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac aneurysm</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>anterior myocardial infarctus</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>6 day</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
|   |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/5</b> , 19 <b>79</b> , to <b>6/11</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/11</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.                         |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>John R. Melnick</b>  |  |  |  | DEGREE<br><b>MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>6/11/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>6-15-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood Pr. Geo. Md.</b>                     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Nalley's F.H. Inc.</b>   |  |  |  | ADDRESS<br><b>Mt. Rainier, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b>   |  |  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert McCreedy</b>  |  |   |  |  |  |

MEDICAL CERTIFICATION





10.1.1951

10.1.1951

10.1.1951

LELAND HOSPITAL

RIVERDALE

Handwritten notes in cursive script, mostly illegible.

Handwritten notes in cursive script, mostly illegible.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |  |   |  |  |  |  |                             | 15482<br>REG. NO.                            |  |
|--|-------------------------|---|--|---|--|--|--|--|-----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Felix Edward FINZEL</b>   |                         |   |  |   |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>06-24-79</b>           |  | 2b. HOUR<br><b>11:30 PM</b> |  |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4-8-08</b>  |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>71</b>   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.   | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>6-24-79</b>                                |  | 7d. HOUR<br><b>11:30 PM</b>  |                             |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>                            |  | MD   |                             |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>HYATTSVILLE</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>8219 14TH AVENUE</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>U.S. POST OFFICE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |                             |  |  |
| 13a. STATE<br><b>MARYLAND</b>  |                         |   | 13b. COUNTY<br><b>PRINCE GEO.</b>              |   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>8219 14TH AVENUE</b>                 |  |                             |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PATRICK FINZEL</b>  |                         |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JANE BURKEY</b>                  |  |  |  |                             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>   |                         |   | 16b. SOCIAL SECURITY NO.<br><b>578-10-8428</b> |   | 17. INFORMANT<br><b>SON</b>  |  | 17a. ADDRESS<br><b>P. O. BOX 551<br/>HYATTSVILLE, MARYLAND</b> |  |                             |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                         |   |  |   |  |  |  |  |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |   |  |   |  |  |  |  |                             |  |  |
| 19a. DATE OF OPERATION   |                         |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                             |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)            |  |  |                             |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                         |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                             |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |   |  |   |  |  |  |  |                             |  |  |
| ACTUAL SIGNATURE<br><b>Augusto P. Rodriguez</b>  |                         |   |  | TITLE (SPECIFY)<br><b>Reguly</b>  |  |  |  | M.D. MEDICAL EXAMINER  |                             | DATE SIGNED<br><b>6-24-79</b>                |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Augusto P. Rodriguez</b>  |                         |   |  | ADDRESS<br><b>5709 Rayburn Ct., Camp Springs</b>  |  |  |  |  |                             |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>6/28/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. OLIVET CEMETERY</b>  |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WASHINGTON, D. C.</b>   |                             |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>  |                         |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1979</b>                                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patricia Kennedy</b>                    |                             |  |  |
| 500 UNIV. BLVD. W. SILVER SPRING, MD. 20901  |                         |   |  |   |  |  |  |  |                             |  |  |

MEDICAL CERTIFICATION

U.S.A.  
HARRISBURG, PENNSYLVANIA  
2219 14TH AVENUE  
JAMES E. FIVEEL  
P.O. BOX 851  
HARRISBURG, PENNSYLVANIA  
JAMES E. FIVEEL  
P.O. BOX 851  
HARRISBURG, PENNSYLVANIA

FRANCIS J. COLLINS  
2219 14TH AVENUE  
HARRISBURG, PENNSYLVANIA  
JAMES E. FIVEEL  
P.O. BOX 851  
HARRISBURG, PENNSYLVANIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DMHM - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |   |   |  |   |  |   |  |  |
|---|--|---|--|---|---|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Thelma Viola Fletcher</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 12, 1979</b>            |   |   | 2b. HOUR<br><b>2:40A</b> M   |   |  |   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 4, 1908</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash. D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Pr. Geo. Co.</b> MD.  |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pr. Geo. Gen. Hosp.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Office Manager</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Sterling Laundry</b>   |   |  |  |
| 13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>P.G.</b>   |   | 13c. CITY OR TOWN<br><b>Hyattsville</b>                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5902 31st. Ave. Apt-502</b> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alfred J. Webster</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dora Basford</b>   |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |   |  |   | 16b. SOCIAL SECURITY NO.<br><b>578-10-1046</b> |  |
| 17. INFORMANT<br><b>Earline Wyne</b>  |  |   | ADDRESS<br><b>Address Same as No # 13e.</b>                            |   |   |  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary collapse</b><br>3319<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>dehydration</b><br>(c) <b>Cerebral atrophy</b>   |  |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>senile dementia</b>   |  |   |  |   |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 16</b> , 19 <b>78</b> , to <b>June 11</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>June 11</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (thd) (did not) view the body after death. |  |   |  |   |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Don B. Cameron</b>   |  |   |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>6-12-79</b>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Don B. Cameron, M.D.</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>6490 Landover Rd. Cheverly, Md.</b>   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>6-14-79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood P.G. Md.</b>                         |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>F. Gasch's Sons F.H. P.A. Hyatts, Md.</b>  |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 15 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Harry H. Brady</b>  |   |  |  |

MEDICAL CERTIFICATION



2

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

15484

|   |         |   |  |  |   |   |     |   |
|---|---------|---|--|--|---|---|-----|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         |   | 2a. DATE KNOWN OF DEATH  |  |   | 2b. HOUR  |     |   |
| James Charles Floyd   |         |   | ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 13 1979 |  |   | M 3:21 P  |     |   |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH  | 6. AGE   | IF UNDER 1 YR.   |   | IF UNDER 24 HRS.  |     | 7c. DATE PRONOUNCED DEAD  |
| Male  | Black   | 9/7/17  | 61 YRS.  | MONTHS   | DAYS  | HOURS   | MIN | 6 13 1979   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |     |   |
| S.C.  |         | USA   |  |  |   | Prince George's County MD.                                    |     |   |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |     | 12b. KIND OF BUSINESS OR INDUSTRY                                   |
| Cheverly  |         | Prince George's General Hospital  |  |  |   | Retired   |     |   |
| 13a. STATE  |         |   | 13b. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |   |     | 13e. STREET ADDRESS   |
| District of Columbia  |         |   | Washington   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |   |     | 1300 Stevens Road, S.E.   |
| 14. FATHER'S NAME   |         |   | 15. MOTHER'S MAIDEN NAME   |  |   | ADDRESS   |     |   |
| unknown   |         |   | Reba Floyd   |  |   |   |     |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |         |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |   |     |   |
| yes   |         |   | 246 12 0301  |  | Gladys Floyd-wife-1300 Stevens Rd.  |   |     |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |   |  |  |   |   |     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| PART I DEATH WAS CAUSED BY:   |         |   |  |  |   |   |     |   |
| IMMEDIATE CAUSE (a) Intracranial Hemorrhage   |         |   |  |  |   |   |     |   |
| DUE TO, OR AS A CONSEQUENCE OF  |         |   |  |  |   |   |     |   |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.   |         |   |  |  |   |   |     |   |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |         |   |  |  |   |   |     |   |
| (c)   |         |   |  |  |   |   |     |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |         |   |  |  |   |   |     |   |
| Cirrhosis of Liver  |         |   |  |  |   |   |     |   |
| 19a. DATE OF OPERATION  |         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |  |   |   |     | 20. AUTOPSY?  |
|   |         |   |  |  |   |   |     | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                           |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |   |     |   |
|   |         |   | P.M. 19  |  |   |   |     |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)            |  | 21f. LOCATION   |   |     |   |
|   |         |   |  |  | STREET CITY OR TOWN COUNTY STATE  |   |     |   |
| 22. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |   |  |  |   |   |     |   |
| ACTUAL SIGNATURE  |         |   | TITLE (SPECIFY)  |  |   | DATE SIGNED   |     |   |
| Virginia L. Dolan M.D.  |         |   | Assistant  |  |   | 6/15/79   |     |   |
| EXAMINER'S NAME (TYPE OR PRINT)   |         |   | ADDRESS  |  |   |   |     |   |
| Virginia L. Dolan, M.D.   |         |   | 111 Penn Street  |  |   |   |     |   |
| 23a. BURIAL, CREMATION, OR OTHER (SPECIFY)  |         |   | 23b. NAME OF CEMETERY OR CREMATORY                                     |  |   | 23c. LOCATION   |     |   |
| Burial  |         |   | Harmony Memorial Park  |  |   | CITY OR TOWN COUNTY STATE                                     |     |   |
| Landover Maryland   |         |   |  |  |   |   |     |   |
| 24. FUNERAL DIRECTOR NAME   |         |   | 25a. DATE REC'D. BY REGISTRAR  |  |   | 25b. REGISTRAR'S SIGNATURE                                    |     |   |
| Stewart Funeral Home-4001 Benning Road, N.E.  |         |   | JUN 21 1979  |  |   | [Signature]   |     |   |

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.







Items #8a-22a Film G532 6/28/79 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 15485

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
 TERESA R. FORAN

2a. DATE KNOWN OF DEATH MONTH DAY YEAR  
☒ MONTH ☐ MONTH ☐ DAY ☐ YEAR  
 5 8 79 19

2b. HOUR  
 3:30 a

3. SEX female 4. RACE white 5. DATE OF BIRTH MONTH DAY YEAR  
 Oct. 13, 1947 31 YRS. 6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN  
 IF UNDER 1 YR. IF UNDER 24 HRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD

10. CITY OR TOWN OF DEATH Lanham 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctor's Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher - P.G. County -Education 12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE Maryland 13b. COUNTY Prince Georges 13c. CITY OR TOWN Bowie 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 3805 Idle Court

14. FATHER'S NAME FIRST MIDDLE LAST William Phillip Russell 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Katherine Geier

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 219-48-3029 17. INFORMANT ADDRESS James V. Foran, 3805 Idle Court, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I DEATH WAS CAUSED BY:  
 4939 IMMEDIATE CAUSE (a) Chronic asthma with acute exacerbation  
 DUE TO, OR AS A CONSEQUENCE OF  
 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  
 (b)  
 DUE TO, OR AS A CONSEQUENCE OF  
 (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Margaret A. Korell TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 5/9/79

EXAMINER'S NAME (TYPE OR PRINT) Margaretita A. Korell, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE May 11, 1979 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.

24. FUNERAL DIRECTOR Robert G. Beall Funeral Home 25a. DATE REC'D. BY REGISTRAR MAY 16 1979 25b. REGISTRAR'S SIGNATURE

1 2 3 4 5 6 7 8 9 10 11 12

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## RELEASED BY MEDICAL EXAMINER

DHMH - 16 50M 7/77  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |   |                          | 79 15486  |  |
|--|--|--|--|--|--|---|--|---|--------------------------|---|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |  |  |   |  |   |                          |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOSEPH ANTHONY FRATANTUONO</b>   |  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 28, 1979</b>                                     |  |   | 2b. HOUR<br><b>1:40A</b> |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct 5 1903</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                          | IF UNDER 24 HRS.<br>HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>PRINCE GEORGE'S MD.</b>                              |  |   |                          |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>LANHAM</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>DOCTORS' HOSPITAL OF PR. GEO. CO</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Restaurant Ret</b>       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Owner</b>   |                          |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Pr. Geo</b>  |  | 13c. CITY OR TOWN<br><b>College Pk.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>9625 51st Place</b>   |                          |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Fratantuono</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Masino</b>  |  |   |  |   |                          |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br><b>578-24-7935</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Pauline Fratantuono (wife) same as 13e</b>  |  |   |  |   |                          |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>2500 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which } (b) <b>Diabetes Mellitus</b><br>gave rise to immediate }<br>cause (c), stating the } DUE TO, OR AS A CONSEQUENCE OF<br>underlying cause last. } <b>Arteriosclerosis</b><br>(c) |  |  |  |  |  |   |  |   |                          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |   |                          |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                          |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |                          |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |                          |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1973</b> to <b>Present</b> , that (I) (we) lost<br>saw the deceased alive on <b>1 1/2 Months ago</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |   |                          |   |  |
| 22b. SIGNATURE<br><b>Cleo A. Montez</b>  |  |  |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>6-28-79</b>  |                          |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Cleo A. Montez</b>   |  |  |  | 22e. ADDRESS<br><b>3308 Dodge PK Rd. - Landover MD</b>   |  |   |  |   |                          |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>6/28/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crem</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Alexandria, Virginia</b>                       |  |   |                          |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Francis Gasch's Sons, PA Hyattsville, Md.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 2 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b>   |  |   |                          |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |   |  |
|--|--|---|--|---|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 79 15487<br>REG. NO.  |  |   |  |   |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE AND PRINT)<br>Laura C. Frazee  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 8, 1979  |   |  | 2b. HOUR<br>3:20 P.M.  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 30 97  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince Georges County MD.             |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Forestville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Regency Nursing Home |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY<br>Maryland Montgomery  |  |   |  |   | 13c. CITY OR TOWN<br>Bethesda  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>6507 76th Place<br>Cabin John, Md. 20731 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George Humberston  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha Frazee   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>170 50 5920  |  | 17. INFORMANT<br>ADDRESS<br>Wayne R Frazee 6507 76 Pl Cabin John  |  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYLEHDD METAPLASIA<br>515-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CHRONIC FIBROTIC LUNG DISEASE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |   |  |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/21, 19 78, to 6/8, 19 79, that (I) (we) last saw the deceased alive on 6/8, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |   |  |
| 22b. SIGNATURE<br>William Kent Furst   |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br>6-8-79   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William K. Furst  |  |   |  |   | 22e. ADDRESS<br>9401 Indian Head Highway Oxon Hill   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>6-13-1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glade Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Garrett County, Md              |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert E Wilhelm<br>ADDRESS<br>Suitland Maryland   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUN 13 1979   |   |  |  |   |  |

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FOR THE  
FEDERAL  
BUREAU OF  
INVESTIGATION  
UNITED STATES DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535  
ATTENTION: DIRECTOR  
TELEPHONE: (202) 452-2000  
FACSIMILE: (202) 452-2000  
MAILING ADDRESS: 440 ...  
...  
...

UNITED STATES DEPARTMENT OF HEALTH  
AND HUMAN SERVICES  
OFFICE OF THE ASSISTANT SECRETARY FOR  
HEALTH POLICY AND PROGRAMS  
WASHINGTON, D.C. 20201  
ATTENTION: DIRECTOR  
TELEPHONE: (202) 452-2000  
FACSIMILE: (202) 452-2000  
MAILING ADDRESS: 440 ...  
...  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

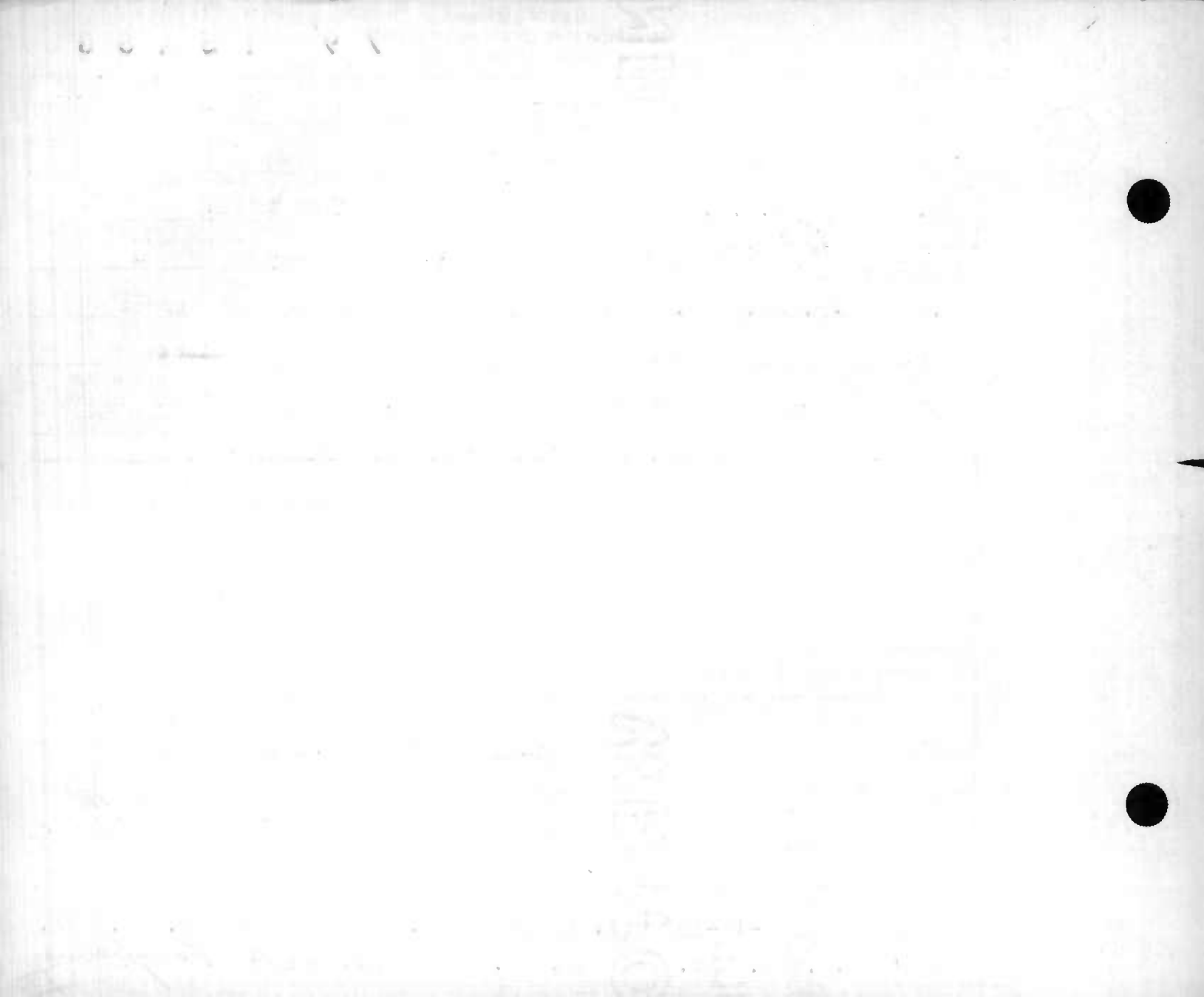
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 15488

|  |  |  |   |   |   |   |   |  |  |
|--|--|--|---|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>NINA V. FULLER  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06-09-79             |   | 2b. HOUR<br>4:35AM  |   |   |  |  |
| 3 SEX<br>Female  |  | 4 RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4-22-1912   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.                                     |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGES MD.                    |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>CHEVERLY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PRINCE GEORGES GENERAL HOSPITAL |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>-           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  |  | 13b. CITY OR TOWN<br>Pr. Geo.                               |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13d. STREET ADDRESS<br>3710 - 35th Street   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ezra Lucas   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susie Seal |   |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-   |   | 17. INFORMANT<br>ADDRESS<br>same as<br>578-26-8736A Charles L. Fuller (Husband) above   |   |   |   |  |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Pancreas</u><br>1579<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>with hepatic metastases 2 months</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ascites 20 to (a)</u>   |  |  |   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 79  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-29</u> , 19 <u>79</u> , to <u>6-8</u> , 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>6/8</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |   |   |   |  |  |
| 22b. SIGNATURE<br><u>A. Sanders</u>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   |   |   | 22c. DATE SIGNED<br><u>6/9/79</u>                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>S. O. Sandler</u>  |  |  |   | 22e. ADDRESS<br><u>6490 Candace Rd.</u>   |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>6-12-79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln Cem.  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brentwood Pr. Geo. Md.          |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Nalley's F.H. Inc.   |  |  |   | ADDRESS<br>Mt. Rainier, Md.   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUN 18 1979                                  |   | 25b. REGISTRAR'S SIGNATURE<br><u>H. H. H. H.</u> |  |







STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 5 4 8 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |  |  |   |  |  |
|---|--|---|---|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   | MIDDLE  | LAST   | 2a DATE OF DEATH MONTH DAY YEAR  |   | 2b HOUR P M  |  |
| Winifred E. GAINES  |  |   |   |  | June 7, 1979   |   | 4:45 M   |  |
| 3 SEX   | 4 RACE   |   | 5 DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |   | IF UNDER 1 YEAR IF UNDER 73 HRS                                |  |
| Female  | Black  |   | Jan 8 1922  |  | 57   |   | MONTHS DAYS HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b CITIZEN OF WHAT COUNTRY?  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |   |  |  |
| Wash., D.C.   | USA  |   |   |  | Prince George County MD.   |   |  |  |
| 10 CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b KIND OF BUSINESS OR INDUSTRY   |   |  |  |
| Glenn Dale  | Glenn Dale Hospital  |   | Nurse   |  |  |   |  |  |
| 13a STATE   | 13b COUNTY   | 13c CITY OR TOWN  | 13d INSIDE CITY LIMITS?   | 13e STREET ADDRESS   |  |   |  |  |
| Washington  | PG   | D/C.  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 431 Warner Street, N.W.  |  |   |  |  |
| 14 FATHER'S NAME  |  |   | 15. MOTHER'S MAIDEN NAME  |  |  |   |  |  |
| Richard Thomas Epps   |  |   | Ella Oggleton   |  |  |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |   | 16b SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS   |   |  |  |
| No  |  |   |   |  | Leroy Gaines 431 Warner St. N.W.   |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY   |  |   |   |  |  |   |  | Days   |
| IMMEDIATE CAUSE (a) <u>Acute Renal Failure</u>  |  |   |   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |  |  |   |  | Years  |
| (b) <u>Hypertension</u>   |  |   |   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |   |  |  |   |  | Years  |
| (c) <u>Arteriosclerosis</u>   |  |   |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |  |   |  |  |
| <u>Chronic Obstructive Pulmonary Disease; Anemia</u>  |  |   |   |  |  |   |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                     |   |  | 20a AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.                   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |
|   |  | 19  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |
|   |  |   |   |  |  |   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 21</u> , 19 <u>79</u> , to <u>June 7</u> , 19 <u>79</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>June 7</u> , 19 <u>79</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |   |  |  |   |  |  |
| 22b. SIGNATURE  |  | DEGREE  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED   |  |
| <u>James Wills</u>  |  | M.D.  |   |  |  |   | June 7, 1979   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |   | 22e. ADDRESS   |  |   |  |  |
| James W. Wills, M.D.  |  |   |   | Glenn Dale Hospital<br>Glenn Dale, Maryland 20769                              |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE |  |  |
| Burial  |  | 6-12-79   |   | Harmony Mem Park   |  | Landover, Maryland                      |  |  |
| 24 FUNERAL DIRECTOR NAME  |  |   |   | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR           |  | 25b. REGISTRAR'S SIGNATURE                   |
| FRAZIERS FUNERAL HOME   |  |   |   | Wash., D.C.<br>389 R.I. AVE N.W.   |  | JUN 14 1979                             |  | <u>Robert J. Brady</u>                       |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

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1943

June 1, 1943

CATHER

Final

Section

British General Hospital

Section

Classical Hospital

Classical

Classical Hospital

Classical Hospital

Classical Hospital

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26

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMM - 16 60M 1/75  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  | 79 15490                                     |  |
|---|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |  |  |  |  |  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>MARION   |  | MIDDLE<br>E  |  | LAST<br>GANO   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>06 21 79   |  | 2b HOUR<br>1:15 P.M.                         |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 16, 1895   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>84   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 8 IF UNDER 24 HRS.<br>HOURS MIN.             |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W.Va.   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGES COUNTY, MD.                              |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>RIVERDALE, MD   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>EUGENE LELAND MEMORIAL HOSPITAL |  |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accountant                  |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Savings & Loan   |  |  |  |
| 13a STATE<br>Md.  |  | 13b COUNTY<br>P.G.  |  | 13c CITY OR TOWN<br>Beltsville   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS<br>10425 Baltimore Ave.   |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>James T. Gano  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lelia K. Robinson   |  |  |  |  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b SOCIAL SECURITY NO.<br>232-01-8500A   |  | 17 INFORMANT ADDRESS<br>Mrs. K. Jane Dudrow 3603 Gleneagles Dr Silver Spring, Md.  |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Metabolic acidosis of unknown etiology with cardiogenic shock</u><br>2762<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Fabry's illness of unknown etiology</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Hours</u><br><u>days</u> |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|   |  |   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Acute aspiration of gastric contents terminally.</u>   |  |   |  |  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>6/17</u> , 19 <u>79</u> , to <u>6/21</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/21</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |  |  |  |  |  |
| 22b SIGNATURE<br><u>Byrl D. Johnson</u>   |  | DEGREE<br><u>M.D.</u>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                 |  |  |  | 22c DATE SIGNED<br><u>6/22/79</u>  |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Byrl D. Johnson, M.D.   |  | 22e ADDRESS<br>4400 Queensbury Rd. Riverdale, Md.   |  |  |  |  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b DATE<br>6-25-79   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Rock Creek Cem.   |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Washington D.C.                                   |  |  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>F. Gasch's Sons F.H. P.A. Hyattsville, Md.   |  |   |  |  |  | 25a DATE RECEIVED BY REGISTRAR 25b REGISTRAR'S SIGNATURE<br>JUN 25 1979 <u>[Signature]</u>     |  |  |  |  |  |

BP

7 2 1 5 4 9 0

|       |              |                |                                      |
|-------|--------------|----------------|--------------------------------------|
| Male  | White        | Jan. 10, 1983  | 84                                   |
| VA.   | U.S.A.       | x              | 10425 Baltimore ave.                 |
| James | T.           | James          | James                                |
| No    | 122-01-8500A | K. Jane Duhrow | 3003 Glenview St. Silver Spring, Md. |

1. Search's name: H. P. A. Newellville, Md.  
Initial: 0-25-78  
Book: Creek Com.  
Washington  
4100 Greenway Rd. Silverdale, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 79 15491  |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST<br>Marsha Ann  |  | MIDDLE<br>Gawthrop  |  | LAST<br>Gawthrop  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>June 16, 1979  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 26 43  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>36 YRS.  |  | 2b. HOUR<br>5:50 P.M.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Illinois   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George MD  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Clinton  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>So. Md. Hosp. Center |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Bank Teller                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Banking   |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Charles   |  | 13c. CITY OR TOWN<br>White Plains   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>Rt. #1 Box 314  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Edward Wint Wood   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Stella Miles  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>578-60-4436  |  | 17. INFORMANT ADDRESS<br>Edward A. Gawthrop same as # 13  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>431-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>142   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-79, to 6-16-79, that (I) (we) last saw the deceased alive on 6-16-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Richard Dohson M.D.   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>6-16-79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Richard Dohson M.D.  |  |  |  | 22e. ADDRESS<br>Brandywine, Maryland  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>6-19-79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Trinity Mem. Gardens  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Waldorf Charles Md.                               |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Hunt Funeral Home  |  |  |  | ADDRESS<br>Waldorf Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 22 1979  |  | 25b. REGISTRAR'S SIGNATURE<br>Barbara McCready   |  |

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UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR  |  | Ffilm#G533 7-12-79   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  | 15492  |  | REG. NO.  |  |
|--|--|--|--|--|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT)<br><b>CARLOS D. GIBBS SR.</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>06 11 79</b>   |  | 2b. HOUR<br><b>4:30A.M.</b>  |  |   |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Caucasian</b>   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09 24 84</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>94</b>  |  | 7a. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>00 00</b>                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Nebraska</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges</b> MD  |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Clinton</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Southern Maryland Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Carpenter</b>  |  |   |  |
| 13a. STATE<br><b>Md.</b>   |  |  |  | 13b. CITY OR TOWN<br><b>Pr. Geo.</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS<br><b>3000 Walters Lane</b>                               |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Isaac C. Gibbs</b>   |  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Evelyn Parker</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>220-10-5443</b>  |  | 17 INFORMANT ADDRESS<br><b>Wilmer C. Gibbs (son) Same as #13</b>   |  |   |  |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Respiratory Arrest</b><br><b>4280 Pneumonia</b> CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Bilateral Pleural Effusions</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Congestive Heart Failure</b> |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 days</b><br><b>2 wks</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Fracture of R. Hip 5/20. Anemia Strain</b>  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>4 P.M. 5 20 79</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>Fell in living room</b>   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>home</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1802 Shady Drive Edgewater, Md.</b>  |  |  |  |   |  |
| 22. I certify that (1) this hospital attended the deceased from <b>6/11/79</b> to <b>6/11/79</b> , that (2) we last saw the deceased alive on <b>6/11/79</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) did not view the body after death, INITIALS)  |  |  |  |  |  |  |  |   |  |
| 23. SIGNATURE<br><b>Kelvin L. Minchin</b>  |  |  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 23c. DATE SIGNED<br><b>6/11/79</b>  |  |
| 23d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KELVIN L. MINCHIN</b>  |  |  |  | 23e. ADDRESS<br><b>6188 OXON HILL RD OXON HILL</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>14 June 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland PG MD</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert E. Wilhelm</b>   |  |  |  | ADDRESS<br><b>Suitland, Md.</b>  |  | 25. RECEIVED BY REGISTRAR<br><b>JUN 19 1979</b>  |  | 26. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                               |  |

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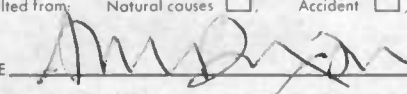

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Prince George  
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Clinton  
Southern Maryland Hospital  
Mr. Geo.  
3000 Helton Lane  
Forestville

220-10-2443

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |  |  |  |  |  |  | REG. NO. 15493  |  |
|--|--|----------------------|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  |                      |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH                                 |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>CHARLIE GILCHRIST</b>  |  |                      |  |  |  |  |  |  |  | 2b. MONTH DAY YEAR <b>6 1 1979</b>                      |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>negro</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>11 30 43</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>35 YRS.</b> |  | 7. IF UNDER 1 YR. MONTHS DAYS  |  | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 1 1979</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's Co.</b>  |  |                      |  | 10. CITY OR TOWN OF DEATH <b>Cheverly</b>  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George's Gen. Hospital</b>             |  |   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>  |  |                      |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  | 12c. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |
| 13a. STATE <b>Maryland</b>   |  |                      |  | 13b. CITY OR TOWN <b>Seat Pleasant</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 13e. STREET ADDRESS <b>6708 Drylog Street</b>  |  |                      |  | 14. FATHER'S NAME FIRST MIDDLE LAST <b>Freddie Lee Gilchrist</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary (unknown)</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>250 72 7771</b>  |  |  |  | 17. INFORMANT <b>Mrs. Audrey Gilchrist-wife</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot wound of head (handgun)</b><br>9650<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |                      |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY HOUR <b>9:55 P.M.</b> MONTH DAY YEAR <b>6-1-1979</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Shot following argument.</b>  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>6708 Drylog St. Seat Pleasant, P.G. Md.</b>  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |                      |  |  |  |  |  |  |  | TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER       |  |
| ACTUAL SIGNATURE    |  |                      |  | DATE SIGNED <b>6-3-79</b>  |  |  |  | EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>  |  |   |  |
| ADDRESS <b>111 Penn St.</b>  |  |                      |  | 23a. BURIAL, CREMATION, REMOVAL  |  |  |  | 23b. DATE <b>6/11/79</b>   |  |   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cemetery</b>  |  |                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>  |  |  |  | 24. FUNERAL DIRECTOR NAME <b>Stewart</b> ADDRESS <b>Funeral Home-4001 Benning Road, NE.</b>  |  |   |  |
| 24a. DATE REC'D BY REGISTRAR <b>JUN 13 1979</b>  |  |                      |  | 24b. REGISTRAR'S SIGNATURE  |  |  |  | BP   |  |   |  |

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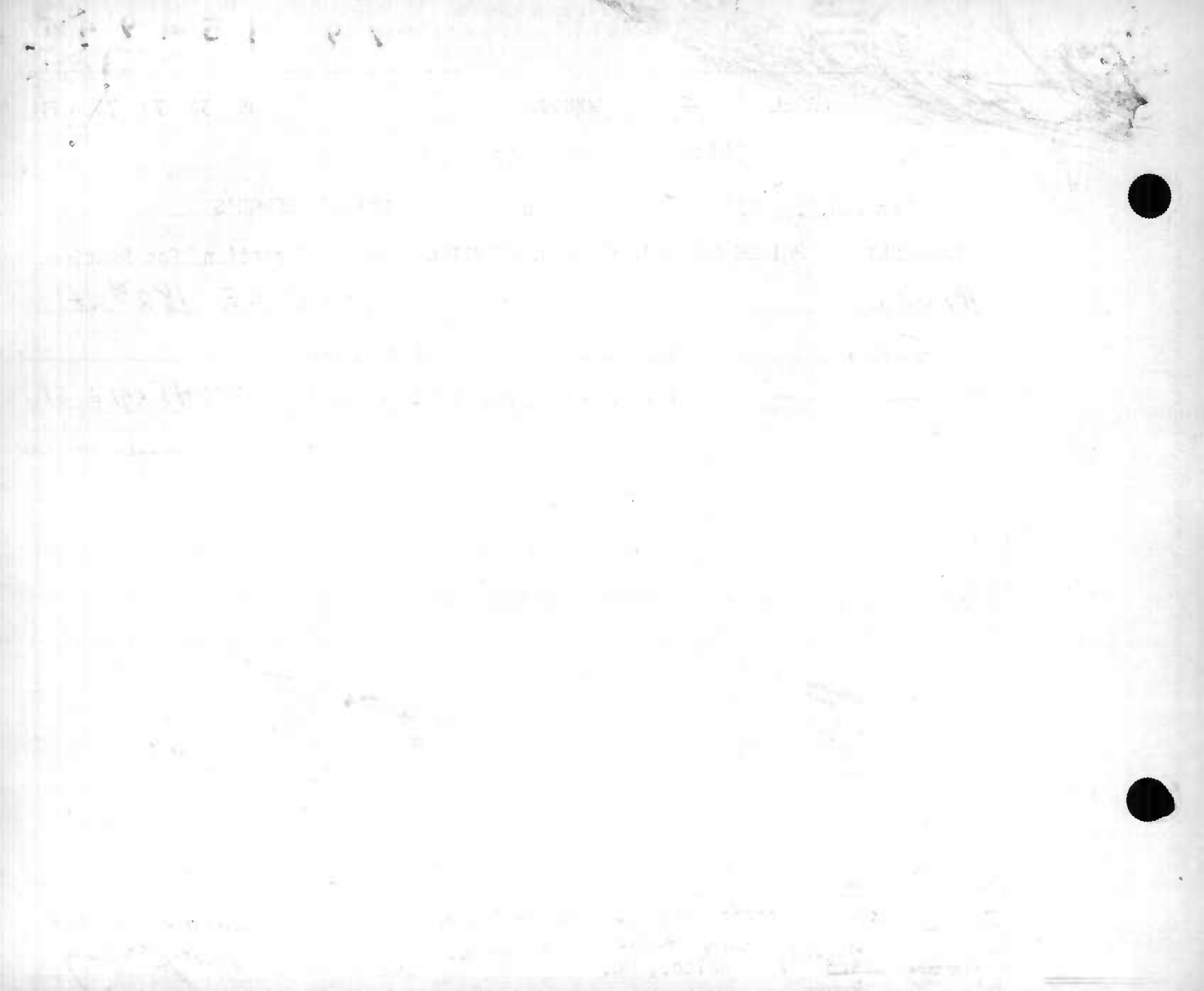
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 7 15494  |  |  |  | REG. NO.   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| MABEL   |  | E.   |  | GORMAN   |  |  |  | 06 30 79  |  | 7:50 PM                                      |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS HOURS MIN                    |  |
| Female  |  | White  |  | 9 16 92  |  | 86 YRS.  |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| Wash., D.C.   |  | USA  |  |  |  | PRINCE GEORGE'S MD.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |
| CHEVERLY  |  | PRINCE GEORGE'S GENERAL HOSPITAL   |  | Owner of station   |  | Gas Station  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS   |  |  |  |
| Florida   |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 1755 N.E. 182nd St  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |   |  |  |  |
| JOHN  |  | NITZE  |  |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO  |  | 17. INFORMANT  |  | ADDRESS  |  |   |  |  |  |
| No  |  | UNKNOWN  |  | CHARLES BROWN  |  | 2104 EAGLE ST  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio Resp. arrest 2° to</u><br><u>0389</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Sepsis</u> and <u>C.V.A.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-28</u> 19 <u>79</u> , to <u>6-30</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-30</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE <u>Robert Ruderman, M.D.</u> DEGREE _____  |  |  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED 6/30/79  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT RUDERMAN, M.D.   |  |  |  |  |  | 22e. ADDRESS 6201 GREENBELT RD., COLLEGE PARK, MD.   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal   |  | 23b. DATE 7/7/79   |  | 23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURHIE Md   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME Anatomy Board   |  | 24b. FUNERAL HOME ADDRESS KUN. HOME 130 E. FORT BALTO., Md.  |  | 25a. DATE REC'D. BY REGISTRAR JUL 18 1979  |  | 25b. REGISTRAR'S SIGNATURE <u>Robert Ruderman</u>  |  |   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| FOR<br>1 - STATE<br>REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   | REG. NO. 7 9 1 5 4 9 5   |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GOLDIE G GRAY</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 3 79</b>                                  |  | 2b. HOUR<br><b>8<sup>20</sup> A M</b>                           |
| 3. SEX<br><b>female</b>   | 4. RACE<br><b>white</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan 20, 1891</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88 years</b>                                   | # UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS</b>                     |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Pro Georges county</b> MD.                |   |
| 10. CITY OR TOWN OF DEATH<br><b>Greenbelt</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greenbelt Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <b>Md</b> 13c. COUNTY <b>Pro Georges</b> 13d. CITY OR TOWN <b>Brentwood</b>  |  |   | 13e. STREET ADDRESS<br><b>3605 Taylor St.</b>   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>(Father's Name Unknown)</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>(First Name Unknown) Goodhart</b> |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>577-34-8473D</b>  |   | 17. INFORMANT<br>ADDRESS <b>1 Silverwood Circle Annapolis, Md.</b>                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Coronary Artery</b>   |  |   |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Years</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerotic Heart Disease</b>   |  |   |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Carcinoma of Colon</b>   |  |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |  |   |
| 19a. DATE OF OPERATION<br><b>1976, 1976</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma of Colon</b>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>5-24-79</b> , to <b>6-3-79</b> , that (1) (we) (we) saw the deceased alive on <b>5-24-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |   |   |  |   |
| 22b. SIGNATURE<br><b>David Schachter</b>  |  | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>6-3-79</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David Schachter</b>   |  | 22e. ADDRESS<br><b>115 Antwerp, Greenbelt Md.</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>6-6-79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>                    |   |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Brentwood</b>   |  | COUNTY<br><b>P.G.</b>   |   | STATE<br><b>Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>F. Gasch's Sons F.H. P.A. Hyatts. Md.</b>  |  |   | 25a. DATE RECEIVED BY REGISTRAR<br><b>JUN 5 1979</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                |



SECRET



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |  |  |        |  |      |  |                                 |  |                    |  |                  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|--------|--|------|--|---------------------------------|--|--------------------|--|------------------|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 15496  |  | REG. NO.   |  |  |  |   |  |  |  |        |  |      |  |                                 |  |                    |  |                  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2e. DATE OF DEATH   |  | MONTH  |  | DAY    |  | YEAR |  | 2b. HOUR                        |  | AM                 |  |                  |  |
| Alma  |  | JB   |  | Green  |  |  |  | 06  |  | 15   |  | 79     |  | 7:00 |  |                                 |  | M                  |  |                  |  |
| 3. SEX  |  | F  |  | 4. RACE  |  | White  |  | 5. DATE OF BIRTH  |  | MONTH  |  | DAY    |  | YEAR |  | 6. AGE (IN YEARS LAST BIRTHDAY) |  | 7. IF UNDER 1 YEAR |  | IF UNDER 24 HRS. |  |
| July  |  | 21   |  | 1891   |  | 7  |  | 87  |  | YRS.   |  | MONTHS |  | DAYS |  | HOURS                           |  | MIN.               |  |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |        |  |      |  |                                 |  |                    |  |                  |  |
| South Carolina  |  | USA  |  |  |  | Prince Georges County MD.                                      |  | housewife   |  | home   |  |        |  |      |  |                                 |  |                    |  |                  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12c. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |   |  |  |  |        |  |      |  |                                 |  |                    |  |                  |  |
| Laurel  |  | Greater Laurel Beltsville Hospital   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 12501 Gunpowder Road   |  |   |  |  |  |        |  |      |  |                                 |  |                    |  |                  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?                                       |  | 13e. STREET ADDRESS   |  |  |  |        |  |      |  |                                 |  |                    |  |                  |  |
| Md  |  | PG   |  | Beltsville   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 12501 Gunpowder Road  |  |  |  |        |  |      |  |                                 |  |                    |  |                  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.                                       |  | 17. INFORMANT   |  | ADDRESS                                      |  |        |  |      |  |                                 |  |                    |  |                  |  |
| Tandy Bruce   |  | Lula Fleming   |  | no   |  | 251 09 1646  |  | James H. Jones  |  | same as above                                |  |        |  |      |  |                                 |  |                    |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF                                 |  | DUE TO, OR AS A CONSEQUENCE OF                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |        |  |      |  |                                 |  |                    |  |                  |  |
| 1991  |  | Cardiac Arrest   |  | 1991   |  | 1991   |  | 1991  |  | minutes                                      |  |        |  |      |  |                                 |  |                    |  |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  | 1991   |  | 1991   |  | 1991   |  | 1991  |  | weeks  |  |        |  |      |  |                                 |  |                    |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |  |  |  |        |  |      |  |                                 |  |                    |  |                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |   |  |  |  |        |  |      |  |                                 |  |                    |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |        |  |      |  |                                 |  |                    |  |                  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET   |  | CITY OR TOWN   |  | COUNTY  |  | STATE  |  |        |  |      |  |                                 |  |                    |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from May 29, 1979, to June 15, 1979, that (I) (we) last saw the deceased alive on June 14, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. |  | 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |  |  |        |  |      |  |                                 |  |                    |  |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 6/15/79  |  |   |  |  |  |        |  |      |  |                                 |  |                    |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN                                     |  | COUNTY  |  | STATE  |  |        |  |      |  |                                 |  |                    |  |                  |  |
| Burial  |  | June 1979  |  | Woodlawn Cemetery  |  | Greenville, South Carolina                                     |  |   |  |  |  |        |  |      |  |                                 |  |                    |  |                  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  | JUN 19 1979  |  |   |  |  |  |        |  |      |  |                                 |  |                    |  |                  |  |



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## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   | REG. NO. 15497  |  |
|--|--|--|---|---|--|
| 1 DECEASED NAME (TYPE OR PRINT)<br><b>MARY GREEN</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>06 27 79</b>  |   | 2b. HOUR<br><b>1:30A</b>  |  |
| 3. SEX<br><b>FEMALE</b>  | 4 RACE<br><b>N</b>   | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>Aug, 28, 21</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>S.C.</b>  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>PRINCE GEORGES</b> MD                             |  |
| 10 CITY OR TOWN OF DEATH<br><b>CHEVERLY</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PRINCE GEORGES GENERAL HOSPITAL</b> |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b> |   | 12b KIND OF BUSINESS OR INDUSTRY             |
| 13a STATE<br><b>Md.</b>  |  | 13b COUNTY<br><b>P.G.</b>  | 13c CITY OR TOWN<br><b>Marlow Hgt</b>   | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Lewis Ada Thomas</b>  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Georgia Nichols</b>  |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b SOCIAL SECURITY NO.<br><b>Unk</b>  |   | 17 INFORMANT ADDRESS<br><b>Lucy McPherson, Same</b>   |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>terminal metastatic carcinoma</b> |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |  |   |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |   |   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>6-23-79</b> to <b>6-27-79</b> , that (I) (we) last saw the deceased alive on <b>6-27-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |
| 22b SIGNATURE<br><b>ROBIN A. ELY M.D.</b>  |  | DEGREE<br><b>Resident</b>  |   | 22c DATE SIGNED<br><b>6/27/79</b>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robt. Ely M.D.</b>  |  | 22e ADDRESS<br><b>Cheverly Md.</b>   |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b DATE<br><b>6-30-79</b>   |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Harmony Cem</b>                                     |  |
| 23d LOCATION CITY OR TOWN<br><b>Landover Md.</b>   |  | 23e COUNTY STATE   |   |   |  |
| 24 FUNERAL DIRECTOR NAME<br><b>VANNE Williams</b>  |  | ADDRESS<br><b>4804 G.A. Ave NW</b>   |   | 25a DATE REC'D. BY REGISTRAR<br><b>JUL 6 1979</b>   |  |
| 25b REGISTRAR'S SIGNATURE<br><b>Hickory</b>  |  |  |   |   |  |

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**Medical Examiner's Office**  
 TO HOSPITAL OR ATTENDING PHYSICIAN: To be completed and filed within 24 hours after death. If death occurred within 72 hours after death, the medical examiner must be notified of cause.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 79 15498  |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Evelyn Eugenia Griffith</b>  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>June 9, 1979</b>   |  | 7b. HOUR <b>7:32Pm</b>  |  |
| 3 SEX <b>Female</b>  |  | 4 RACE <b>Caucasian</b>   |  | 5 DATE OF BIRTH <b>Sept. 22, 1902</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b>   |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's</b> MD.                               |  |   |  |
| 10 CITY OR TOWN OF DEATH <b>Clinton</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>D.O.A. Prince Georges Hosp.</b> |  |   |  | 12a. OCCUPATION (TYPE OR NATURE OF WORKING LIFE) <b>Retired Government</b>                   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>GSA</b>  |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>P.G.</b>   |  | 13c. CITY OR TOWN <b>Clinton</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>9503 Small Dr.</b>   |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>Phillip S. Griffith</b>  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Della A. Wolfe</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO. <b>578-28-2586</b>   |  | 17 INFORMANT ADDRESS <b>Patrick Murphy Same as 13a-e</b>  |  |  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADVANCE CARCINOMA OF PHARYNX C</b><br>1490 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>NECK METASTASIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b> |  |   |  |   |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>NOV</b> , 19 <b>78</b> , to <b>MARCH</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>28 JUNE</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |
| 22a. SIGNATURE <b>[Signature]</b>  |  |   |  | DEGREE  |  |  |  | 22c. DATE SIGNED <b>6/10/79</b>   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARNALDO A. GARRO M.D.</b>   |  |   |  | 22e. ADDRESS <b>3710 CIVIC ST MARLOW HEIGHTS MD</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>6/13/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Elkins Old Fellows Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkins Randolph W. Va.</b>                        |  |   |  |
| 24 FUNERAL DIRECTOR'S NAME <b>Lee Funeral Home Inc.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 14 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |  |
| 6633 Old Alexander Ferry Rd. Clinton, Md.  |  |   |  |   |  |  |  |   |  |



U.S. DEPARTMENT OF JUSTICE

6633 Old Alexander Ferry S. Clinton,  
Lee Funeral Home Inc.  
Burial

Wayland, I.C. Clinton

Philip S. Griffith

Clinton D.O.A. Prince Georges County, Md.

9563 (April 1954)

William A. Galt

278-28-1000

1. 1954 study was on 1954

1954

Sept. 27, 1954

June 9, 1954

7:32

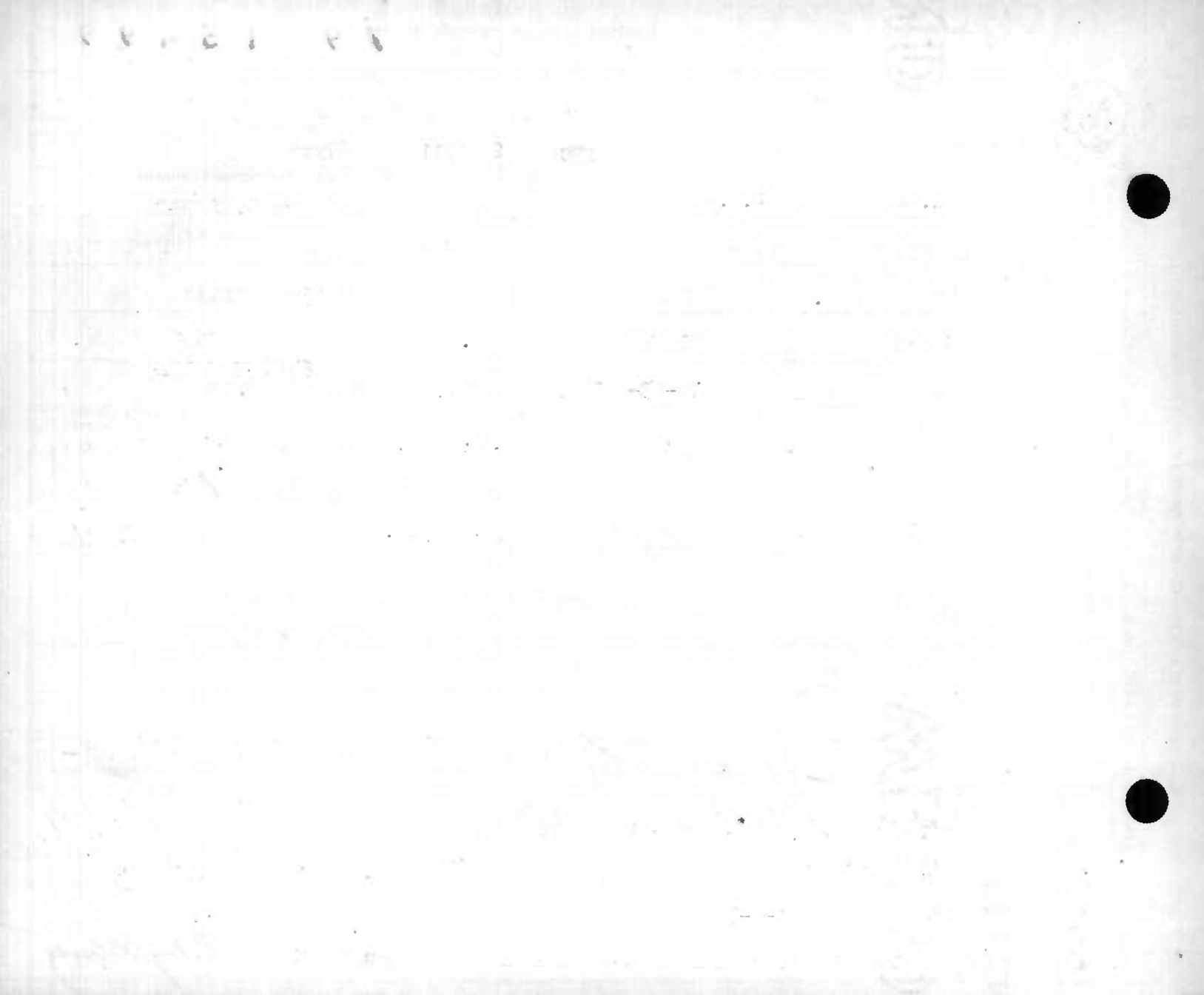


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |  |  |   |  |  |  |
|--|--|---|---|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 7 9 1 5 4 9 9   |   | REG. NO.   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>TRACY R GRIFFITH   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06 01 79 |  |  | 2b. HOUR<br>10:40 P M   |  |  |  |
| 3 SEX<br>MALE  |  | 4 RACE<br>CAU   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC 2 1911   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>67yrs YRS   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W.Va  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGE'S COUNTY MD.                               |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>CHEVERLY   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PRINCE GEORGE'S GENERAL HOSPITAL |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>MANAGER                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>LITTLE TAVERNS  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MD  |  | 13b. COUNTY<br>P.G  |   | 13c. CITY OR TOWN<br>HILLCREST HGTS  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>4008 23rd PARKWAY   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HARRY GRIFFITH   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>DORA RAY  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES  |  | (IF YES, GIVE WAR OR DATES)<br>WWII   |   | 16b. SOCIAL SECURITY NO.<br>579-03-5734  |  | 17 INFORMANT<br>6415 BIRCHLEAF CT<br>SON RONALD GRIFFITH, BURKE Va                              |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardio Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>arterio Sclerotic Heart</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>acute MYOCARDIAL INFARCTION</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 Day</u><br><u>2 wks</u><br><u>2 wks</u> |  |   |   |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 19</u> 19 <u>79</u> to <u>JUNE 1</u> 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>JUNE 1</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Samuel N. Sugar MD</u>  |  |   |   | DEGREE<br>MD   |  |   |  | 22c. DATE SIGNED<br><u>6/2/79</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>SAMUEL N. SUGAR   |  |   |   | 22e. ADDRESS<br>4637 EASTERN AVE WASHINGTON DC 20018   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   |  | 23b. DATE<br>1-5-79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>WASH NAT CEMETERY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SUITLAND P.G MD                                   |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>GEO P KALAS 6160 OXON HILL RD OXON HILL Md  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUN 5 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Barney McGandy</u>   |  |  |  |





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15500

|   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELSIE MARGARET GURNEY</b>               |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 19, 1979</b> |   |  | 2b. HOUR<br><b>5.00</b> P.M.  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 12, 1918</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>61</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kansas</b>                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges Co. MD.</b>                           |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lanham</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Doctors Hospital of Pr. Geo. Co.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mgt. Specialist</b>      |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't.</b>            |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>P.G.</b>   |   | 13c. CITY OR TOWN<br><b>Cheverly</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6511 Landover Rd. Apt - T-3</b>          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry F. Gurney</b>                  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Flossie J. Kinney</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>577-10-8387</b>  |   | 17. INFORMANT<br>ADDRESS <b>Address Same as No # 13e.</b>   |  |   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

**Sepsis**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**48 hours****1820**

Conditions, if any, which  
gave rise to immediate  
cause (d), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

**Metastatic Endometrial Carcinoma****1 year**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)          |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>15 Feb 1979</b> to <b>19 Jan 1979</b> , that (I) (we) last saw the deceased alive on <b>19 Jan 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Thomas A. Benning MD</b>  |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>6/20/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas A. Benning</b>  |  |  |  | 22e. ADDRESS<br><b>831 University Blvd E. Silsby Maryland 20903 (Thomas A. Benning)</b> |  |   |  |

|   |  |                             |  |  |  |  |  |
|---|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                     |  | 23b. DATE<br><b>6-23-79</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Kidder Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Kidder Caldwell, Missouri</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 22 1979</b>          |  | 25b. RECORDING SIGNATURE<br><i>[Signature]</i>                                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

11

U.S. DEPARTMENT OF AGRICULTURE



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  |   |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 7. 9   |  | 15501   |  | REG. NO.   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR  |  |
| WILLIS   |  | L.   |  |   |  | HAINES   |  | 06-19-1979  |  | 10.40 P.M.  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR MONTHS DAYS  |  | 8. IF UNDER 24 HRS. HOURS MIN.  |  |
| Male   |  | White  |  | April 15, 1913  |  | 66   |  |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |   |  |
| W.Va.  |  | U.S.A.   |  |   |  | PRINCE GEORGE'S COUNTY MD.   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  |   |  |   |  |
| CHEVERLY   |  | PRINCE GEORGE'S GENERAL HOSPITAL   |  |   |  |  |  |   |  |   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |  |   |  |   |  |
| Automobile Dealer  |  | Automobile   |  |   |  |  |  |   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   |  |  |  |   |  |   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |  |   |  |
| Md.  |  | P.G.   |  | Largo   |  |  |  | 12012 Hunterton St.   |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |  |   |  |
| Elmer L. Haines  |  |  |  |   |  | Leona Shillenburg  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)  |  |  |  | 17. INFORMANT ADDRESS   |  |   |  |
| No   |  |  |  | 579-18-5081   |  |  |  | Ruby M. Haines Same as # 13   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 2500 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>possible Myocardial infarction</u>  |  |  |  |   |  |  |  |   |  | 36 hours  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u>  |  |  |  |   |  |  |  |   |  | 20+ years   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Renal Failure</u>   |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |
|  |  |  |  | P.M. 19   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
|  |  |  |  |   |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/18</u> 19 <u>77</u> to <u>6/19</u> 19 <u>77</u> , that (I) (we) lost saw the deceased alive on <u>6/18</u> 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE <u>[Signature]</u>  |  |  |  | DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED <u>6/20</u>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Steven Pollak</u>   |  |  |  | 22e. ADDRESS <u>4700 Auth Place, Camp Springs</u>   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  |  |  | 23b. DATE <u>6-22-79</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>                               |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brentwood, P.G. Md.</u> |   |  |
| 24. FUNERAL DIRECTOR <u>F. Gasch's Sons, P.A. Hyattsville, Md.</u>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <u>JUN 22 1979</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>                                     |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1000000000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |   |  |  |  |  |
|--|--|--|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | REG. NO. 15502  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Rebekah Hamilton</b>   |  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>June 15, 1979</b>   |  |  |  |  |
| 3. SEX <b>female</b>   |  |  |  |  | 2b. HOUR <b>4:25a</b> M   |  |  |  |  |
| 4. RACE <b>white</b>   |  |  |  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>November 27, 1989</b>  |  |  |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.   |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges' County</b> MD.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Largo</b>   |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Nursing Home</b> |  |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Artist</b>  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Self employ.</b>   |  |  |  |  |
| 13a. STATE <b>Maryland</b>   |  |  |  |  | 13b. COUNTY <b>Charles</b>  |  |  |  |  |
| 13c. CITY OR TOWN <b>La Plata</b>  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |
| 13e. STREET ADDRESS <b>Box 163 603 Wicomico Street</b>   |  |  |  |  | 14. FATHER'S NAME FIRST MIDDLE LAST <b>Pere Wilmer</b>  |  |  |  |  |
| 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Amelie Matthews</b>  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |  |  |  |
| 16b. SOCIAL SECURITY NO. <b>218-34-6430</b>  |  |  |  |  | 17. INFORMANT ADDRESS <b>Margaret W. Reep 13814 North East Place Redmond, Washington 98052</b>  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>436-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>6/15/79</b> |  |  |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Generalized arteriosclerosis</b>   |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>               |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5/25/79</b> P.M. <b>19</b>  |  |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK                                |  |  |  |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  |  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (I) <b>W. P. Joneskey MD</b> attended the deceased from <b>June 13, 1979</b> to <b>June 15, 1979</b> , that (I) <b>last</b> saw the deceased alive on <b>June 13, 1979</b> , and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.             |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE <b>W. P. Joneskey MD</b>  |  |  |  |  | 22c. DATE SIGNED <b>June 15, 1979</b>   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WENDY P. JONESKEY</b>   |  |  |  |  | 22e. ADDRESS <b>7601 Riverdale Road, New Carrollton, Md 20784</b>   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |  |  |  | 23b. DATE <b>6-18-1979</b>  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Mount Rest Cemetery</b>  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>La Plata Charles Maryland</b>  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Archard Funeral Home, Inc.</b> ADDRESS <b>20646 La Plata, Maryland</b>  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1979</b> 25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>                                   |  |  |  |  |

BP



12005



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A 15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

15503

|  |  |   |  |   |  |   |  |   |  |   |  |   |  |               |  |
|--|--|---|--|---|--|---|--|---|--|---|--|---|--|---------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANN Owens HAND</b> |  |   |  |   |  |   |  |   |  | 2a. DATE KNOWN<br>OF DEATH<br>ESTI-<br>MATED <input checked="" type="checkbox"/> 6 25 19 79 |  | 7b. HOUR<br>M |  |
| 3. SEX<br><b>female</b>  |  | 4. RACE<br><b>white</b>                                   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 14, 1922</b>  |  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br><b>56</b> YRS.                    |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 2c. DATE<br>PRONOUNCED<br>DEAD <b>6 25 19 79</b>                                    |  | 7c. HOUR<br>a M   |  |               |  |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br><b>South Carolina</b>  |  |   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's Co.</b> MD.                      |  |               |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Prince George's Gen. Hosp. (DOA)</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br><b>Secretary</b>  |  |   |  | 12b. KIND OF BUSINESS<br>OR INDUSTRY<br><b>Sears Co.</b>                                    |  |               |  |
| 13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY<br><b>P.G. Co.</b>  |  | 13c. CITY OR TOWN<br><b>Adelphi</b>                                     |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>9200 Edwards Way Apt 804</b>                              |  |   |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Corneilus B. Owens</b>  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maebel Williams</b> |  |   |  |   |  |   |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No.</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>250-18-5961</b>  |  | 17. INFORMANT<br><b>Robert O. Hand Laurel, Md. 20810</b>                |  |   |  |   |  |   |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fatty metamorphosis of the liver</b><br>5718<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                       |  |   |  |   |  |   |  |   |  |   |  |   |  |               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.  |  |   |  |   |  |   |  |   |  |   |  |   |  |               |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |               |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN  |  | COUNTY STATE  |  |               |  |
| 22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |   |  |   |  |   |  |               |  |
| ACTUAL<br>SIGNATURE <b>Ann M. Dixon</b>  |  |   |  | TITLE (SPECIFY)<br><b>Assistant</b> MEDICAL EXAMINER  |  |   |  |   |  | DATE<br>SIGNED <b>6-26-79</b>   |  |   |  |               |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>   |  |   |  | ADDRESS <b>111 Penn St.</b>   |  |   |  |   |  |   |  |   |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |   |  | 23b. DATE<br><b>6/28/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. National Mem. Park</b>     |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Laurel, E.G. Co. Md.</b>           |  |   |  |               |  |
| 24. FUNERAL DIRECTOR<br><b>FLECK LAUREL FUNERAL HOME, INC.</b><br><b>7601 Sandy Spring Rd. Laurel, Md. 20810</b>   |  |   |  |   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 28 1979</b>                                 |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patrick McBrady</b>  |  |               |  |

BP



1 2 3 4 5



FOR  
STATE  
REGISTRAR

Items 12a, 17 g532 6/22/79 g5  
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15504

|   |                  |   |   |   |  |  |  |
|---|------------------|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HARVEY FOSTER</b>   |                  |   | 2b. DATE KNOWN OF DEATH<br>ESTI. <input checked="" type="checkbox"/> MONTH DAY YEAR<br>MATED. <input type="checkbox"/> 6-6-1979 |   |  | 2c. DATE OF DEATH<br>Pronounced DEAD<br>June 6 1979                      | 2d. HOUR<br>8:05   |
| 3. SEX<br>Male  | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>10-11-23  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>55 YRS.   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.                                     |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, D.C.   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George's                  |  |
| 10. CITY OR TOWN OF DEATH<br>Lanham   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Doctors' Hospital of Pr. Geo. Co. |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK)<br>Auto Painter |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Salesman Rogers Chevrolet |
| 13a. STATE<br>Maryland  |                  | 13b. COUNTY<br>PR. Geo.   | 13c. CITY OR TOWN<br>Bowie  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS<br>12402 Sarah Lane              |  |  |
| 14. FATHER'S NAME,<br>FIRST MIDDLE LAST<br>H Harvey Foster Harmon   |                  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ethel Mae Barnes   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>yes  |                  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW II  |   | 17. INFORMANT<br>Harmon<br>Leona M. <del>Rhodes</del> Same as # 13  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral sclerotic cardio vascular disease</u><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1  |                  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                  |   |   |   |  |  |  |
| ACTUAL SIGNATURE<br><u>August P. Rodriguez</u>  |                  | TIME (SPECIFY)<br>M.D. <u>July</u>  |   | MEDICAL EXAMINER  |  | DATE SIGNED <u>6-7-79</u>  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>August P. Rodriguez   |                  | ADDRESS<br>5009 Rayburn Ct., Camp Springs   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |                  | 23b. DATE<br>9 JUN 79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lakemont Memo Gardens   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Davidsonville, Md.         |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robert G. Beall Funeral Home  |                  |   |   | 25a. DATE<br>JUN 13 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>W.D. Sullivan</u>                       |  |
| 9013 Annapolis Rd. Lanham, Md. 20801  |                  |   |   |   |  |  |  |

100-2-18-1

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |                              |  |  |   |  |  |  |
|---|--|---|---|---|------------------------------|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Henry Lillard Harrison, Sr.</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 4, 1979</b> |   | 2b. HOUR<br><b>8:00 a.m.</b> |  |  |   |  |  |  |
| 3 SEX<br><b>Male</b>  |  | 4 RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 12, 1920</b>  |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>15</b> MONTHS <b>10</b> DAYS      |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.<br><b>15</b> HOURS <b>10</b> MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's</b> MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Riverdale</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Eugene Leland Memorial Hospital</b> |   |   |                              | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Assist. Secretary</b>   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>State Senate.</b>                      |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Pr. Geo's</b> 13c. CITY OR TOWN <b>Riverdale</b>   |  |   |   |   |                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George S. Harrison</b>   |  |   |   |   |                              | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Helena -- Gibbons</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Unk.</b>   |  |   |   | 16b. SOCIAL SECURITY NO.  |                              | 17. INFORMANT<br>ADDRESS<br><b>Mary H. Barksdale-5910 85th Place,<br/>New Carrollton, Md.</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>1890 METASTATIC ADENOCARCINOMA OF (R) KIDNEY</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20784 1 1/2 YRS</b> |  |   |   |   |                              |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____   |  |   |   |   |                              |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                              |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |                              | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                              | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 1979</b> to <b>JUNE 3, 1979</b> , that (I) (we) last saw the deceased alive on <b>JUNE 3, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.   |  |   |   |   |                              |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>James A. Brown</b>   |  |   |   |   |                              | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>6/4/79</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James A. Brown, M. D.</b>   |  |   |   |   |                              | 22e. ADDRESS<br><b>6525 Belcrest Road, Hyattsville, Md.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   |   | 23b. DATE<br><b>6/6/79</b>  |                              | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Trinity Cemetery</b>  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Upper Marlboro (P.G.) Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>Richard A. Coleman-Upper Marlboro, Maryland 20870</b>  |  |   |   |   |                              | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 12 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                          |  |  |  |



4

| Name               | Address          | City          | State  | Country |
|--------------------|------------------|---------------|--------|---------|
| George S. Hamilton | 1000 14th Avenue | San Francisco | Calif. | U.S.A.  |
| Mary A. Garkhatia  | 2010 8th Place   | San Francisco | Calif. | U.S.A.  |
| John               |                  |               |        |         |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | REG. NO. 15506   |  |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Julian C. HARRISON, Jr.</b>  |  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>6-16</b> 19 <b>79</b>  |  | 2b. HOUR   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>5</b> YEAR <b>46</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>38</b> YRS.  |  | 7. IF UNDER 1 YR.<br>MONTHS <b>0</b> DAYS <b>0</b>                       |  | 7c. DATE PRONOUNCED DEAD<br>MONTH <b>10</b> DAY <b>16</b> YEAR <b>79</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore City</b>  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>OXON HILL</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>12214 PARKTON COURT</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>TRUCK DRIVER</b>                           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PARCEL</b>                       |  |  |  |
| 13a. STATE<br><b>D.C.</b>   |  | 13b. COUNTY<br><b>Washington</b>   |  | 13c. CITY OR TOWN<br><b>DC</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                           |  | 13e. STREET ADDRESS<br><b>2112 Maybelle Road SE #303</b>                 |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>HULIAN</b> MIDDLE <b>CURTIS</b> LAST <b>HARRISON, SR.</b>   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>UNKNOWN</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>                     |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>YES</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>UNKNOWN</b>  |  | 17. INFORMANT<br>NAME <b>GOLDIE A. HARRISON (SAME AS DECEDENT)</b> ADDRESS <b>UNKNOWN</b>                      |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Drowning</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>9102</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>9102</b>  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR <b>6</b> A.M. MONTH <b>6</b> DAY <b>16</b> YEAR <b>79</b><br>P.M. <b>4</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Drowned while swimming</b> |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Home</b>  |  | 21f. LOCATION<br>STREET <b>12214 Parkton Ct.</b> CITY OR TOWN <b>Fort Washington</b> COUNTY <b>Allegheny</b>   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Augusta P. Rodriguez</b>  |  |  |  | TITLE (SPECIFY) <b>M.D.</b>   |  |  |  | DATE SIGNED <b>6-17-79</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Augusta P. Rodriguez</b>   |  |  |  | ADDRESS <b>5009 Bayburn Ct., Camp Springs, Md 20746</b>   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(CHECK ONE)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>6/22/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>WASHINGTON NAT'L CEM.</b>  |  |  |  | 23d. LOCATION<br>CITY OR TOWN <b>SUITLAND</b> COUNTY <b>MARYLAND</b>     |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>ROBERT G. MASON, INC.</b> ADDRESS <b>WASHINGTON, D.C.</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>                    |  |  |  |

00000000



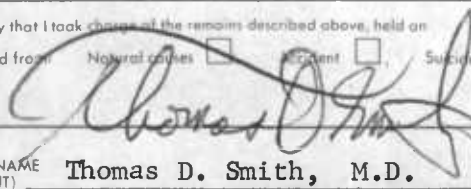

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VIA A15 ME (5))  
15M/7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15507

|   |  |  |  |  |  |   |  |   |  |   |  |  |  |
|---|--|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST<br>LAURA   |  | MIDDLE<br>LEE  |  | LAST<br>HARRISON                                      |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED                                |  | X MONTH DAY YEAR<br>JUNE 6 24 19 79   |  | 2b. HOUR<br>M<br>12:32 P.M.                  |  |
| 3. SEX<br>female  |  | 4. RACE<br>black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec 10, 1930   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>48 YRS.         |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.                            |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>JUNE 6 24 19 79   |  | 2d. HOUR<br>P.M.                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>X Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States  |  | 8. MARRIED X NEVER MARRIED<br>WIDOWED DIVORCED   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George |  |   |  |   |  | MD   |  |
| 10. CITY OR TOWN OF DEATH<br>Cheverly   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Prince George Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cook-N.I.H.                       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Government       |  |   |  |   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN<br>Wash., D.C.   |  | 13d. INSIDE CITY LIMITS?<br>YES X NO                  |  | 13e. STREET ADDRESS<br>711 Kearney St., N.E.                        |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry Reeves  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Georgia Starke  |  |  |  |   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>no   |  | (IF YES, GIVE WAR OR DATES)  |  | 16b. SOCIAL SECURITY NO.<br>225 38 7744  |  | 17. INFORMANT<br>Mother                               |  | ADDRESS<br>Georgia Starke-711 Kearney St., N.E.D.C.                 |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 9651 shotgun wound of abdomen (12 gauge)<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |   |  | 20. AUTOPSY?<br>YES X NO  |  |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>9:00xx 6/24 19 79   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>shot by assailant |  |   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK NOT WHILE AT WORK X   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>home  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>4701 Bennett Ave., Suitland, P.G. County, MD  |  |   |  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy X, inspection, inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide X, Undetermined manner.  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>  |  | TITLE (SPECIFY)<br>Deputy Chief  |  |  |  |   |  | DATE SIGNED<br>6/25/79  |  |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Thomas D. Smith, M.D.   |  | ADDRESS<br>111 Penn Street, Baltimore, MD 21201  |  |  |  |   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>June 28, 79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lincoln Memorial Cem   |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, PG Maryland |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>ALEXANDER S. POPE   |  | ADDRESS<br>2617 Pennsylvania Ave S.E.  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 2 1979                         |  | 25b. REGISTRAR'S SIGNATURE<br> |  |  |  |

1550

JUNE

JUNE

Dec 10, 1930

United States

Cook-W.I.E.

The Kennedy Co., N.Y.

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George W.I.E. Kennedy Co., N.Y.

Wash., D.C.

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George W.I.E. Kennedy Co., N.Y.

Wash., D.C.

George W.I.E. Kennedy Co., N.Y.

George

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ALABAMA & THE ...

DR. RODRIGUEZ RELEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 7 9 1 5 5 0 8  |  |  |  | REG. NO.   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR                               |  | 2b. HOUR P M                                 |  |
| JOHN CARROLL HARTMAN   |  |  |  |  |  |  |  | June 16, 1979  |  | 8.08 P M                                     |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | 7. IF UNDER 1 YEAR MONTHS DAYS                                 |  | 8. IF UNDER 24 HRS HOURS MIN                 |  |
| Male   |  | Caucasian  |  | Nov. 17, 1928  |  | 50 YRS   |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |  |
| Pennsylvania   |  | U.S.A.   |  |  |  | Prince Georges Co. MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Lanham   |  | Doctors Hospital of Pr. Geo. Co.   |  |  |  |  |  | Plumber  |  | Navy Dept.                                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS  |  |  |  |
| Maryland   |  | Pr. Geo.   |  | New Carrollton   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 6508 Lamont Drive  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |  |  |  |  |
| Charles Carroll Hartman  |  | Rhoda Hartzell   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |  |  |  |  |
| yes  |  | unknown  |  | Martha E. Hartman Same as # 13   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u>   |  |  |  |  |  |  |  |  |  | 2 yrs  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>   |  |  |  |  |  |  |  |  |  | 10 yrs                                       |  |
| (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u>  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |  |  |
|  |  | P.M. 19  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET   |  | CITY OR TOWN   |  | COUNTY   |  | STATE  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>19 69</u> to <u>CURRENT</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>2 weeks Ago</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |  |  |
| <u>Roger B. Ingham, M.D.</u>   |  |  |  |  |  |  |  | 6-17-79  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |
| Roger B. Ingham, M.D.  |  | 5701 85th Ave. New Carrollton, Md. 20784   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| Burial   |  | 20 JUN 79  |  | Fort Lincoln Cemetery  |  | Brentwood, Maryland  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |
| Robert G. Beall  |  | 20801 J. D. Sullivan   |  | JUN 19 1979  |  | <u>History McCreedy</u>  |  |  |  |  |  |
| 9013 Annapolis Rd. Lanham, Md.   |  |  |  |  |  |  |  |  |  |  |  |

00001

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                            |  |   |  |  |  |  |  | REG. NO. 15509   |  |
|---|--|----------------------------|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |                            |  |   |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Roy Johnson HAWKINS Jr.  |  |                            |  |   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 6-29 1979 |  |
| 3. SEX Male   |  | 4. RACE White              |  | 5. DATE OF BIRTH MONTH DAY YEAR 2-17-36   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.  |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN   |  | 2c. DATE PRONOUNCED DEAD 6-29 1979   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia  |  |                            |  | 7b. CITIZEN OF WHAT COUNTRY? U. S. A.   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.                              |  |
| 10. CITY OR TOWN OF DEATH Cheverly  |  |                            |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges Hospital |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attendant  |  | 12b. KIND OF BUSINESS OR INDUSTRY OR SERVICE Station                                 |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                            |  |   |  |  |  |  |  |  |  |
| 13a. STATE Maryland   |  | 13b. COUNTY Prince Georges |  | 13c. CITY OR TOWN Riverdale   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS 34 Bunker Hill Road  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Roy J. Hawkins, Sr.   |  |                            |  |   |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Clem                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes  |  |                            |  | (IF YES, GIVE WAR OR DATES)   |  | 16b. SOCIAL SECURITY NO. Unknown   |  | 17. INFORMANT Brother Charles N. Hawkins, Sr. Riverdale, Md.   |  | ADDRESS 6901 Vallery St.   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hepatic fatty meta morphosis<br>5718<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |                            |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                            |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                            |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                            |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE August P. Rodriguez  |  |                            |  | TITLE (SPECIFY) M.D. Deputy   |  |  |  | MEDICAL EXAMINER   |  | DATE SIGNED 6-30-79  |  |
| EXAMINER'S NAME (TYPE OR PRINT) August P. Rodriguez   |  |                            |  | ADDRESS 5009 Rayburn Court Camp Springs   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  |                            |  | 23b. DATE July 3, 1979  |  | 23c. NAME OF CEMETERY OR CREMATORY Mt. Jackson Cemetery                                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Jackson, Virginia  |  |  |  |
| 24. FUNERAL DIRECTOR NAME Capitol Funeral Service   |  |                            |  |   |  | ADDRESS Fairfax, Virginia  |  | 25a. DATE REC'D. BY REGISTRAR JUL 5 1979   |  | 25b. REGISTRAR'S SIGNATURE Dorothy McCurdy   |  |



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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 15510

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>RAYMOND H. HAYS   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 23, 1979                              |  | 2b. HOUR<br>8.05 <sup>p</sup>  |
| 3. SEX<br>Male   | 4. RACE<br>Caucasian   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>May 24, 1899  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS AM/PM   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince Georges Co. MD.                       |  |
| 10. CITY OR TOWN OF DEATH<br>Lanham  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Doctors Hospital of Pr. Geo Co. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Optical Mech. | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov't                                      |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>P.G.   | 13c. CITY OR TOWN<br>Lanham  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John H Hays  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lula Hoerichs                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>n/a  |   | 17. INFORMANT<br>ADDRESS<br>Emily C. Hays Same as #13                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ischemic Heart Disease, Congestive Heart Failure</u><br>496-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Chronic obstructive pulmonary Disease with Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>14 days |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Abdominal pain possible mesenteric arterial insufficiency</u>  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>June 9</u> , 19 <u>79</u> , to <u>June 23</u> , 19 <u>79</u> , that (b) (we) lost<br>saw the deceased alive on <u>June 23</u> , 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (b) (we) did (did not) view the body after death.  |  |   |   |  |  |
| 22b. SIGNATURE<br><u>C. Hsu</u>  |  | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>June 25, 1979  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHIN-CHUAN Hsu  |  | 22e. ADDRESS<br>6905 Baltimore BLVD Collegepark md 20740  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   | 23b. DATE<br>27 JUN 79   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, Maryland                     |  |
| 24. FUNERAL DIRECTOR<br>NAME Robert G Beall Funeral Home<br>ADDRESS 9013 Annapolis Road Lanham, Md 20801   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUL 2 1979                                       |  | 25b. REGISTRAR'S SIGNATURE<br><u>Heston M. Brady</u>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |                            | 79 15511  |  |                                   |  |
|---|--|---|--|---|--|--|--|---|----------------------------|---|--|-----------------------------------|--|
| 1- FOR<br>STATE<br>REGISTRAR  |  | REG. NO.  |  |   |  |  |  |   |                            |   |  |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DOROTHY I. HEGGE</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 7 1979</b>                            |  |   | 2b. HOUR<br><b>4:31A</b> M |   |  |                                   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 15, 1907</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |                            | IF UNDER 24 HRS.<br>HOURS MIN.  |  |                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wisconsin</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's</b> MD.                   |  |   |                            |   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lanham</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Doctors' Hospital of Pr. Geo. Co.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |                            |   |  |                                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   |  |   |  | 13b. COUNTY<br><b>Pr. Geo.</b>   |  | 13c. CITY OR TOWN<br><b>Bowie</b>   |                            | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Emil Botz</b>  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mabel O'Neill</b>                |  |   |                            |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>n/a</b>   |  | 17. INFORMANT<br><b>Barbara Skogebo</b>   |  | ADDRESS<br><b>3304 New Coach Lane<br/>Bowie, Md. 20715</b>                           |  |   |                            |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Rate respiratory failure</b><br><b>5/12 -</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Emphysema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Pneumothorax, pneumonia</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Pathologic fracture of right r. bx. osteoporosis</b> |  |   |  |   |  |  |  |   |                            | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |                                   |  |
| 19a. DATE OF OPERATION<br><b>5/12/79</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Right r. bx. osteoporosis</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                            |   |  |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5/12/79 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |                            |   |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>5/12/79</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>College Park Md. Prince George's</b>  |  |  |  |   |                            |   |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/12/79</b> to <b>6/7/79</b> , that (I) (we) lost<br>saw the deceased alive on <b>5/12/79</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death.   |  |   |  |   |  |  |  |   |                            | 22b. SIGNATURE<br><b>Tsunie Chandhien, M.D.</b><br>DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6/7/79</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>6201 Greenbelt Rd. College Park Md. T. CHANDHIEN</b>  |  |   |  |   |  |  |  |   |                            | 22e. ADDRESS  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11 JUN 79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oakwood Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Austin, Mower, Minnesota</b>        |  |   |                            |   |  |                                   |  |
| 24. FUNERAL DIRECTOR <b>Robert G. Beall</b> Funeral Home<br>NAME ADDRESS<br><b>9013 Annapolis Rd. Lanham, Md. 20801</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 13 1979</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                            |   |  |                                   |  |

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M7/77

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |  |   |   |  |  |   |  | REG. NO. 15512  |  |
|--|-------------------------|--|--|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Herman G. Heinemann</b>   |                         |  |  |   |   |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 6-23 1979 |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 9-24-20 | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <input checked="" type="checkbox"/> YRS. 58 | IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN <input type="checkbox"/> | 7c. DATE PRONOUNCED DEAD<br>MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 6-23 1979 |  | 2d. HOUR<br>6:33 PM   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Nebraska</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges</b> MD.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lanham</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Doctors Hosp. Of Pr. Geo. Co.</b>     |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Hydraulic Research Eng.</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S.D.A.</b>                                |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                         |  |  |   |   |  |  |   |  |   |  |
| 13a. STATE<br><b>Md.</b>   |                         | 13b. COUNTY<br><b>Pr. Geo.</b>   |  | 13c. CITY OR TOWN<br><b>Lanham</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>6301 Hardwood Dr.</b>                                     |  |   |  |
| 14. FATHER'S NAME<br>FIRST <b>Herman</b> MIDDLE <b>Heinemann</b> LAST <b>Wiese</b>   |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Minnie</b> MIDDLE <b>Wiese</b> LAST <b>Wiese</b>   |   |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>1944-1946</b>   |  | 17. INFORMANT<br><b>Mary A. Heinemann</b>   |   | ADDRESS<br><b>Same as # 13</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>4029</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(c) <b>4029</b>  |                         |  |  |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |                         |  |  |   |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |   |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |  |   |   |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Augusto P. Rodriguez</b>  |                         | TITLE (SPECIFY)<br><b>M.D. Deputy</b>  |  |   |   | MEDICAL EXAMINER   |  | DATE SIGNED<br><b>6/24/79</b>   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Augusto P. Rodriguez, M.D.</b>  |                         | ADDRESS<br><b>5009 Rayburn Ct., Camp Springs, Md. 20031</b>  |  |   |   |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         | 23b. DATE<br><b>6-27-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Md. Vet. Cem.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cheltenham Pr. Geo. Md.</b>   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert G. Beall Funeral Home</b>  |                         |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 2 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John M. M...</b>  |  |   |  |   |  |
| ADDRESS<br><b>9013 Annapolis Rd. Lanham, Md.</b>   |                         |  |  |   |   |  |  |   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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DHMM-16 20M  
(VRA 15, 4) 7/78

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |   |   |   |  |
|---|--|--|--|---|---|---|---|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 7 15513  |  | REG. NO.  |   |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RUTH S HERBERT</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>6</b> DAY <b>6</b> YEAR <b>79</b>                      |   |   | 2b. HOUR<br><b>2A</b> M   |   |   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>12</b> YEAR <b>'06</b>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash. D.C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>          |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Pr. Geo. Co.</b> MD.  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Greenbelt</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greenbelt Conv. Center</b> |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Operator</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Telephone</b> |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>P.G.</b>   |  | 13c. CITY OR TOWN<br><b>College Park</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                               |   | 13e. STREET ADDRESS<br><b>5004 Cheyenne Place</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>James</b> MIDDLE <b>Hugh</b> LAST <b>Bradley</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Parmelia</b> MIDDLE <b>E.</b> LAST <b>Soper</b> |   |   | ADDRESS <b>Address Same as No # 13e.</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>577-20-5308</b>   |  | 17 INFORMANT<br><b>James H. Herbert, Jr.</b>  |   |   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SEPSIS &amp; PNEUMONIA</b><br><b>5909</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Renal Tract Infection</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes mellitus</b>                     |  |  |  |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>(1) Diabetes mellitus (2) Arteriosclerosis (3) C.V.A.</b>  |  |  |  |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>12/12/1976</b> to <b>6/6/1979</b> , that (1) (we) lost<br>saw the deceased alive on <b>6-5-1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (1) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>David S. Schachter</b>   |  |  |  | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>6-6-79</b>   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAVID S. Schachter</b>  |  |  |  | 22e. ADDRESS<br><b>115 Centerway, Greenbelt, Md 20770</b>   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>6-9-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>George Wash. Cemetery</b>  |   | 23d. LOCATION<br>CITY OR TOWN<br><b>Adelphi</b>   |   | COUNTY<br><b>P.G.</b> STATE<br><b>Md.</b>         |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>F. Gasch's Sons F.H. P.A.</b>   |  |  |  | ADDRESS<br><b>Hyattsville, Md.</b>  |   | 25a. DATE SIGNED BY REGISTRAR<br><b>JUN 11 1979</b>   |   | 25b. REGISTERED SIGNATURE<br><b>[Signature]</b>   |  |

U I C C I V



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | REG. NO. 15514 |  |
|---|--|---|--|---|--|---|--|--|--|----------------|--|
| 1- FOR STATE REGISTRAR  |  | 1 DECEASED NAME (TYPE OR PRINT) <b>John George Hilt</b>   |  |   |  | 2a DATE OF DEATH MONTH <b>June</b> DAY <b>23</b> YEAR <b>79</b>                     |  | 2b HOUR <b>3:45pm</b>  |  |                |  |
| 3 SEX <b>male</b>   |  | 4 RACE <b>Caucasian</b>   |  | 5 DATE OF BIRTH MONTH <b>2</b> DAY <b>22</b> YEAR <b>02</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS  |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>                                |  |                |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>  |  | 7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>PG</b> MD                                    |  |  |  |                |  |
| 10 CITY OR TOWN OF DEATH <b>Clinton</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Md. Hosp. Center</b> |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic - Ret.</b> |  | 12b KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>   |  |                |  |
| 13a STATE <b>Md.</b>  |  | 13b COUNTY <b>Pr. Geo.</b>  |  | 13c CITY OR TOWN <b>Hillside</b>  |  | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>    |  | 13e STREET ADDRESS <b>1620 Pacific Ave. S.E.</b>   |  |                |  |
| 14 FATHER'S NAME FIRST <b>Ludwig</b> MIDDLE <b></b> LAST <b>Hilt</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Kate</b> MIDDLE <b></b> LAST <b>Eisert</b>  |  |   |  |   |  |  |  |                |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  | 16b SOCIAL SECURITY NO. <b>578-16-4071</b>  |  | 17 INFORMANT <b>Alma Hilt</b>   |  | ADDRESS <b>1620 Pacific Ave. Spalding Hgts., Maryland</b>                           |  |  |  |                |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> 185-<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Emaciation</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cancer Prostate</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Aplastic Anemia</b> |  |   |  |   |  |   |  |  |  |                |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-18</b> 19 <b>79</b> , to <b>6-23</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6-23</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |                |  |
| 22b. SIGNATURE <b>Rene E. Grace</b> DEGREE <b>MD</b>  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  |   |  | 22c. DATE SIGNED <b>23 June 79</b>   |  |                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rene E. Grace MD</b>   |  |   |  | 22e. ADDRESS <b>9131 Pisgataway Rd. Clinton MD-20755</b>  |  |   |  |  |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>6/26/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN <b>Suitland Pr. Geo. Maryland</b> COUNTY STATE           |  |  |  |                |  |
| 24 FUNERAL DIRECTOR NAME <b>George P. Kalas Funeral Home</b> ADDRESS <b>6160 Oxon Hill Rd. Oxon Hill, Md.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 27 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                       |  |  |  |                |  |

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Continued

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE PLACED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |  |  |   |  |  |  | 15515<br>REG. NO.  |  |
|---|--|-------------------------|--|--|--|---|--|--|--|--|--|
| 1- STATE REGISTRAR  |  |                         |  |  |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Max Trumble HINER</b>  |  |                         |  |  |  |   |  |  |  | 2a. DATE KNOWN OF DEATH ESTIMATED<br>MONTH DAY YEAR<br><b>6-1 1979</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH (MONTH DAY YEAR)<br><b>2-9-16</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.                             |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN   |  | 2b. DATE PRONOUNCED<br>MONTH DAY YEAR<br><b>6-1 1979</b>                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges</b> MD.        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Prince George's Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Guard - Pr Geo</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Health Dept</b>                  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                         |  |  |  |   |  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  |                         |  | 13b. COUNTY<br><b>Prince Geo</b>   |  | 13c. CITY OR TOWN<br><b>Hillcrest Hgts</b>                                    |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>2104 Jameson Road</b>                          |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)<br><b>Unknown</b>   |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)<br><b>Addie Mae Gutschall</b>    |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>223 12 3473</b>   |  | 17. INFORMANT<br><b>Father Church, Va. Elizabeth H Day 2854 Dover Lane</b>    |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary atherosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                         |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                         |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Augusto P. Rodriguez</b>   |  |                         |  | TITLE (SPECIFY)<br><b>M.D. Agent</b>   |  |   |  | MEDICAL EXAMINER   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Augusto P. Rodriguez</b>  |  |                         |  | ADDRESS<br><b>5009 Rayburn Ct., Camp Springs Md 20746</b>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                         |  | 23b. DATE<br><b>6-4-1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>              |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert E Wilhelm Funeral Home</b><br>ADDRESS<br><b>Suitland Maryland</b>   |  |                         |  |  |  | 25a. DATE RECD. BY REGISTRAR<br><b>JUN 11 1979</b>                            |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur J. [Signature]</b>   |  |  |  |



Virginia

University

Marshall

Johnson

No

1973 12 12

William H. Day

2834 Boyer Ave

Falls Church, Va.

Colonial

W.C.

White

Belmont

Prince Geo

John A. Johnson

Prince George's Hospital

Quincy - 12 Geo

Health Dept

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

15516

|  |         |   |                   |  |                     |
|--|---------|---|-------------------|--|---------------------|
| 1. FOR STATE REGISTRAR   |         | 2a. DATE KNOWN OF DEATH                                     |                   | 2b. HOUR   |                     |
| DECEASED NAME (TYPE OR PRINT)  |         | DATE KNOWN OF DEATH   |                   | HOUR   |                     |
| WILLIS E. HINES  |         | 6 18 19 79  |                   | 10:52  |                     |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR.  | 8. IF UNDER 24 HRS. |
| male   | black   | May 26 60 19 YRS.   | 19 YRS.           | MONTHS   | DAYS                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                                |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     |
| Va.  |         | USA   |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                     |
| Md   |         | Prince George General Hospital                              |                   | Prince George's County   |                     |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                     |
| Md   |         | Prince George General Hospital                              |                   | Student Aid  |                     |
| 13a. STATE   |         | 13b. COUNTY   |                   | 13c. CITY OR TOWN  |                     |
| Va   |         | Hampton   |                   | 326 Cherry Avenue  |                     |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                    |                   | 16. SOCIAL SECURITY NO.  |                     |
| Waverly Hines  |         | Mildred Granger   |                   | Unk  |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.                                    |                   | 17. INFORMANT  |                     |
| No   |         | Unk   |                   | Waverly Hines/father/same as 13e   |                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |   |                   |  |                     |
| PART I DEATH WAS CAUSED BY:  |         |   |                   |  |                     |
| IMMEDIATE CAUSE (a) <b>Cranio-cerebral trauma</b>  |         |   |                   |  |                     |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |                   |  |                     |
| (b) <b>8136</b>  |         |   |                   |  |                     |
| DUE TO, OR AS A CONSEQUENCE OF   |         |   |                   |  |                     |
| (c)  |         |   |                   |  |                     |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.  |         |   |                   |  |                     |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                   | 20. AUTOPSY?   |                     |
|  |         |   |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                     |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY   |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                     |
|  |         | 9:12 A.M. 6 18 19 79  |                   | bicyclist struck by auto   |                     |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR NOT WHILE AT WORK <input checked="" type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                   | 21f. LOCATION  |                     |
|  |         | highway   |                   | Beantown Road  |                     |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |   |                   |  |                     |
| TITLE (SPECIFY)  |         |   |                   |  |                     |
| M.D. Assistant MEDICAL EXAMINER  |         |   |                   |  |                     |
| DATE SIGNED 6/20/79  |         |   |                   |  |                     |
| EXAMINER'S NAME (TYPE OR PRINT)  |         |   |                   |  |                     |
| Ann M. Dixon, M.D.   |         |   |                   |  |                     |
| ADDRESS  |         |   |                   |  |                     |
| 111 Penn Street  |         |   |                   |  |                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE   |                   | 23c. NAME OF CEMETERY OR CREMATORY   |                     |
| Burial   |         | 6-23-79   |                   | Church   |                     |
| 24. FUNERAL DIRECTOR   |         | 24b. DATE REC'D. BY REGISTRAR                               |                   | 25b. REGISTRAR'S SIGNATURE   |                     |
| John T. Rhines Co.   |         | JUN 25 1979   |                   | L. H. Crady  |                     |
| NAME   |         | ADDRESS   |                   |  |                     |
| 3015 12th St., N.E., D. C.   |         |   |                   |  |                     |



01001 11



Medical Examiner not notified

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |   |  |  |  |   |  |
|--|--|---|---|---|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |   |   | REG. NO. 9 15517  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>ANTHONY H. A. Hiser</b>   |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>06-13-79</b>   |  |  | 2b. HOUR<br><b>7:23 PM</b>   |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Sept 1, 1904</b>  |   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.                            |  | 7. IF UNDER 1 YEAR IF UNDER 24 HRS<br>MONTHS DAYS HOURS MIN |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash. D. C.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>PRINCE GEORGE'S COUNTY MD.</b>    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>CHEVERLY</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PRINCE GEORGE'S HOSPITAL</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic Ret.</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Elevator Co.</b>   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Pr. Geo's</b> 13c. CITY OR TOWN <b>Hyattsville</b>  |  |   |   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>5008 52nd Avenue</b>                               |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John Hiser</b>   |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Anna M. Schubel</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  |   |   |   | 16b. SOCIAL SECURITY NO<br><b>215-14-7411</b>   |  | 17. INFORMANT ADDRESS<br><b>Winifred Mullikin (sister) same as blk 13e</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Terminal Carinoma OF lung</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Anemia.</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): |  |   |   |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 22</b> , 19 <b>77</b> , to <b>MAY 27</b> , 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>MAY 27</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Rakesh Arora</b>  |  |   |   |   | DEGREE<br><b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><b>6/14/79</b>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAKESH ARORA</b>   |  |   |   |   | 22e. ADDRESS<br><b>PGGH, Cheverly, Maryland</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  |   | 23b. DATE<br><b>6/15/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Crematory</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood Pr. Geo's Md.</b> |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Francis Gasch's Sons, PA Hyattsville, Md.</b>  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Luttrell</b>                                |  |   |  |

6300 BP

SECRET

SECRET

SECRET

SECRET



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 22 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15518

|   |  |  |   |  |                  |                          |                                      |   |  |               |  |
|---|--|--|---|--|------------------|--------------------------|--------------------------------------|---|--|---------------|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE KNOWN OF DEATH  |   | 3. MONTH   |                  | 4. DAY                   |                                      | 5. YEAR   |  | 6. HOUR       |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2b. DATE KNOWN OF DEATH  |   | 3. MONTH   |                  | 4. DAY                   |                                      | 5. YEAR   |  | 6. HOUR       |  |
| Troy A. HOLIMON   |  | 6-7 1979   |   | 6-7  |                  | 19                       |                                      | 79  |  | 8             |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS)   | IF UNDER 1 YR.   | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | 8. BALTIMORE CITY OR COUNTY OF DEATH |   |  |               |  |
| Male  | Black  | 12-17-59   | 19  |  |                  | 6-7 1979                 | Baltimore City                       |   |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?                             | 8. MARRIED   |   | NEVER MARRIED  |                  | DIVORCED                 |                                      | 9. BALTIMORE CITY OR COUNTY OF DEATH                                      |  |               |  |
| Fla   | U. S. A.   | WIDOWED  |   | NEVER MARRIED  |                  | DIVORCED                 |                                      | Baltimore City  |  |               |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                  |                          |                                      |   |  |               |  |
| Largo   | 404 Pritchard Lane                                       | Security Guard   |   |  |                  |                          |                                      |   |  |               |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |                  |                          |                                      |   |  |               |  |
| Md  | P.G.   | Largo  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 404 Pritchard Lane   |                  |                          |                                      |   |  |               |  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME                                 | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |   | 16b. SOCIAL SECURITY NO.   |                  | 17. INFORMANT            |                                      | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  |               |  |
| Eugene Holimon  | Betty Stewart  | No   |   | 265-39-9974  |                  | M. H. M. Brooks Aunt     |                                      | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  |               |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY?   |                  |                          |                                      |   |  |               |  |
|   |  |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |                  |                          |                                      |   |  |               |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY  |   | 21c. HOW INJURY OCCURRED   |                  |                          |                                      |   |  |               |  |
|   |  | 6-7 1979   |   | hanged self.   |                  |                          |                                      |   |  |               |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION  |                  |                          |                                      |   |  |               |  |
|   |  | Home   |   | 404 Pritchard Lane, Largo, Md.   |                  |                          |                                      |   |  |               |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:  |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |   | 22b. I certify that I took charge of the remains described above, held on death resulted from: |                  |                          |                                      |   |  |               |  |
| Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |  |                  |                          |                                      |   |  |               |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)  |   | DATE SIGNED  |                  |                          |                                      |   |  |               |  |
| Augusto P. Rodriguez  |  | M.D. Deputy  |   | 6-8-79   |                  |                          |                                      |   |  |               |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS  |   | 23a. BURIAL, CREMATION, REMOVAL  |                  | 23b. DATE                |                                      | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION |  |
| Augusto P. Rodriguez  |  | 5009 Rayburn Ct., Camp Springs, Md   |   |  |                  | 6-12-79                  |                                      | Oak Ridge   |  | Hacienda Flt. |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |                  |                          |                                      |   |  |               |  |
| NAME  |  | JUN 14 1979  |   | Dorothy McCurdy  |                  |                          |                                      |   |  |               |  |
| 145. W. Washington  |  |  |   |  |                  |                          |                                      |   |  |               |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>IRVIN SHERLOCK HOLMES</b>                |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>06 15 79</b>  |   | 2b. HOUR<br><b>4:20p</b> M                                     |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 14 23</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>55</b> YRS  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges County</b> MD.                        |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Clinton</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTHERN MARYLAND HOSPITAL CENTER</b> | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b>   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Store Giant Food</b>                                    |   |  |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. CITY OR TOWN<br><b>Pr. George's Temple Hills</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>5803 Fisher Rd. Apt. #202</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Andrew Holmes</b>                     |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eunice Seale</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b> | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII 225-24-9111</b>  | 17. INFORMANT<br>ADDRESS<br><b>Mary T. Holmes 5803 Fisher Rd. #202 Temple Hills, Maryland</b>   |   |   |  |

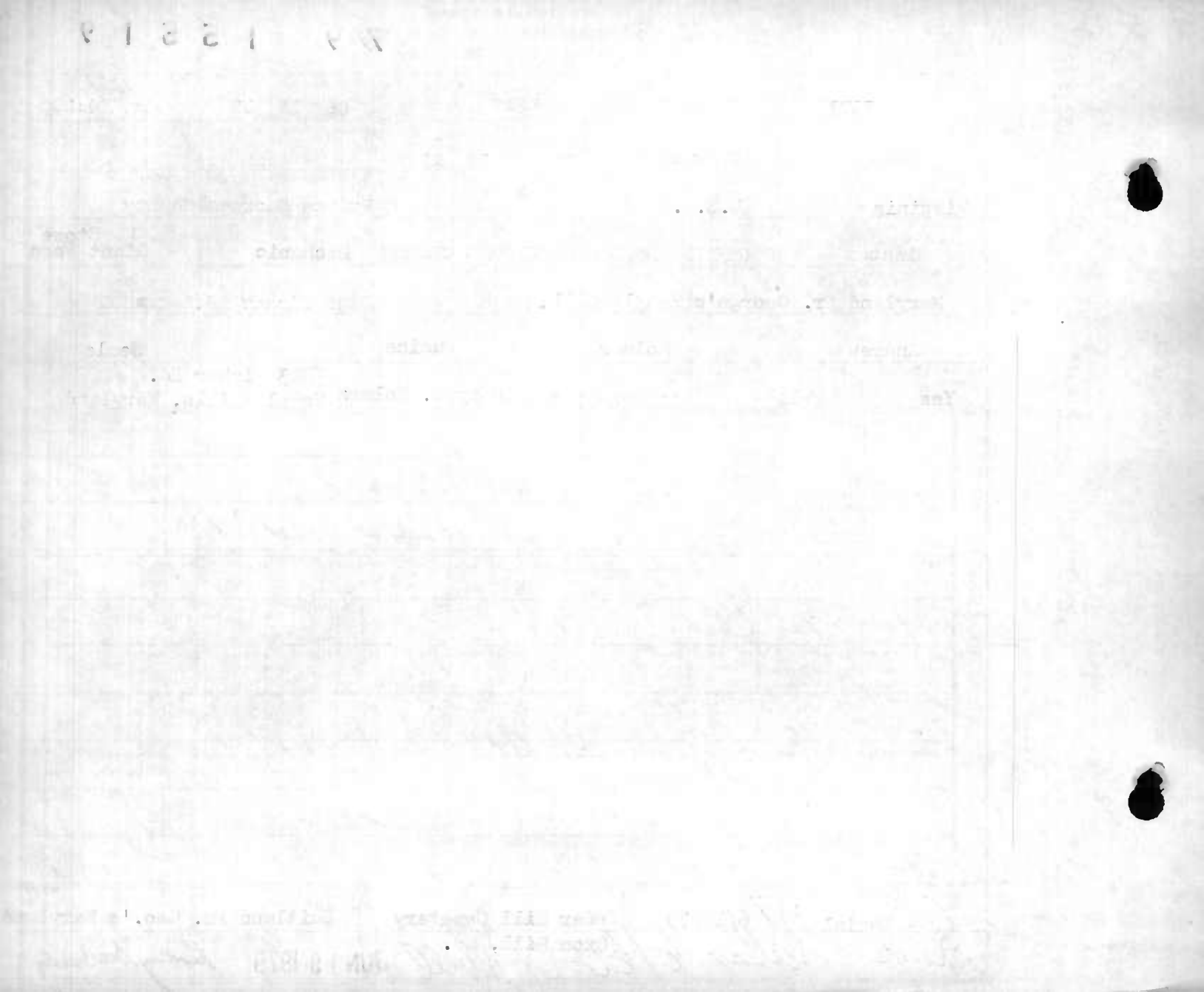
|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Septicemia</b><br><b>5751</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Presumed Clostridia</b><br>(c) <b>Bite Infection - Clostridia</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 hrs.</b> |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION<br><b>6/14/79</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Cholecystitis</b> | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/13/79</b> , 19____, to <b>6/15/79</b> , 19____, that (I) (we) lost saw the deceased alive on <b>6/15/79</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Bernard F. Perceock M.D.</b>  |  | 22c. DATE SIGNED<br><b>6/15/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Bernard F. Perceock M.D.</b>   |  | 22e. ADDRESS<br><b>4d28 Branch Pk. S.E. Marlow Heights</b>                           |  |

|   |                             |  |   |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT)<br><b>Burial</b>             | 23b. DATE<br><b>6/18/79</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland Pr. Geo.'s Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>George Palas 6160 Oxon Hill, Md.</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 19 1979</b>              | 25b. REGISTRAR'S SIGNATURE<br><b>Barbara McCready</b>                             |

W 1 2 2 1 0 8





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |  |   |  |
|---|--|---|--|--|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 7 9 15520   |  | REG. NO.   |  |   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>WILLIAM BRUCE HOOFNAGLE   |  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>JUNE 17, 1979  |  | 2b HOUR<br>6:45P M  |  |   |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Apr. 12, 1905   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George's MD.                          |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>LANHAM  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>DOCTORS HOSP. OF P. G. CO. |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Service Foreman - Tel. Co.  |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Md.   |  |   |  | 13b COUNTY<br>P.G.   |  | 13c CITY OR TOWN<br>Dist. Hgts  |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Hoofnagle   |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elnora Martin  |  |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b SOCIAL SECURITY NO.<br>577-01-3020  |  | 17 INFORMANT<br>ADDRESS<br>Above<br>Ethel M. Hoofnagle, Wife, Same as  |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE RENAL FAILURE</u><br><u>4292</u><br>DUE TO (b) <u>ARTERIO-SCLEROTIC CARDIO VASCULAR DISEASE</u><br>OR AS A CONSEQUENCE OF (c) <u>CANCER OF LUNGS &amp; PROSTATE</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |  |  |   |  |   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>June 4</u> , 19 <u>1979</u> , to <u>June 17</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>June 17</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                   |  |   |  |  |  |   |  |   |  |
| 22b SIGNATURE<br><u>Benjamin S Pecson</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  |   |  | 22c DATE SIGNED<br><u>6-18-79</u>   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Benjamin S Pecson, M.D.   |  |   |  | 22e ADDRESS<br>6106 Old Silver Hill Road<br>District Heights, Md. 20028  |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b DATE<br>6-20-79   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Crematory  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, P.G., Md.                    |  |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>Robt E Wilhelm<br>Funeral Home   |  |   |  | ADDRESS<br>4308 Suitland Rd., Suitland, Md.  |  | 25a DATE REC'D. BY REGISTRAR<br>JUN 25 1979   |  | 25b REGISTRAR'S SIGNATURE<br><u>Anthony M. Brady</u>  |  |



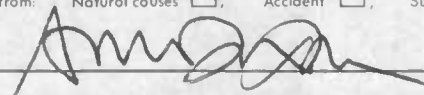

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



Items #10a-22a Film G534 8/31/79 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15521

|  |  |                         |                      |   |  |   |  |   |      |                  |  |   |  |  |                         |   |  |  |  |
|--|--|-------------------------|----------------------|---|--|---|--|---|------|------------------|--|---|--|--|-------------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Susan</b>  |  |                         | FIRST<br><b>Gail</b> |   |  | MIDDLE<br><b>Horton</b>                           |  |   | LAST |                  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>6 20 1979</b> |  |  | 2b. HOUR<br><b>1:37</b> |   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b> |                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 -25 -1943</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>35</b> YRS. |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |      | IF UNDER 24 HRS. |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>6 21 1979</b>  |  |  | 2d. HOUR<br><b>1:37</b> |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |  |                         |                      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |      |                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's County, MD.</b>                                  |  |  |                         |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |  |                         |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Prince George's General Hospital (DOA)</b> |  |   |  |   |      |                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sec.</b>                                |  |  |                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Legal</b>   |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                         |                      |   |  |   |  |   |      |                  |  |   |  |  |                         |   |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  |                         |                      | 13b. COUNTY<br><b>Prince Georges</b>  |  |   |  | 13c. CITY OR TOWN<br><b>Riverdale</b>   |      |                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |                         | 13e. STREET ADDRESS<br><b>6210 Fernwood Terrace</b> |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Furman Horton</b>   |  |                         |                      |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mattie Lee Brown</b>  |      |                  |  |   |  |  |                         |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                         |                      | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |  |   |  | 17. INFORMANT (mother)<br><b>Mrs. Mattie Lee Horton</b>   |      |                  |  | ADDRESS<br><b>6 Alex Lane Glen Cove, N.Y.</b>   |  |  |                         |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>7969</b> IMMEDIATE CAUSE (a) <b>Undetermined</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                         |                      |   |  |   |  |   |      |                  |  |   |  |  |                         |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.  |  |                         |                      |   |  |   |  |   |      |                  |  |   |  |  |                         |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |      |                  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |  |  |                         |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |      |                  |  |   |  |  |                         |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |                         |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |      |                  |  |   |  |  |                         |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> . |  |                         |                      |   |  |   |  |   |      |                  |  |   |  |  |                         |   |  |  |  |
| ACTUAL SIGNATURE<br>  |  |                         |                      | TITLE (SPECIFY)<br><b>Assistant</b>   |  |   |  | MEDICAL EXAMINER  |      |                  |  | DATE SIGNED<br><b>6/22/79</b>   |  |  |                         |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>  |  |                         |                      | ADDRESS<br><b>111 Penn Street</b>   |  |   |  |   |      |                  |  |   |  |  |                         |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |                         |                      | 23b. DATE<br><b>6/26/1979</b>   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Roslyn Cemetery</b>  |      |                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Roslyn Nassau N.Y.</b>                                     |  |  |                         |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>E. Barnes</b>   |  |                         |                      | ADDRESS<br><b>Fleming Funeral Service - Benson, Md. 21018</b>   |  |   |  | 25a. DATE RECEIVED BY REGISTER<br><b>JUN 27 1979</b>  |      |                  |  | REGISTERED BY<br>      |  |  |                         |   |  |  |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 15522

|  |  |  |   |  |                                   |   |  |
|--|--|--|---|--|-----------------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |   | 2a. DATE OF DEATH MONTH DAY YEAR   |                                   | 2b. HOUR  |  |
| CONSTANCE PATRICIA   |  | Housewright  |   | JUNE 29, 1979  |                                   | 6:15 a.m.   |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR  |   | 6. AGE (IN YEARS LAST BIRTHDAY)  |                                   | IF UNDER 1 YEAR MONTHS DAYS   |  |
| FEMALE   | WHITE  | APRIL 16, 1928   |   | 51 YRS.  |                                   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                                   |   |  |
| MASSACHUSETTS  | USA  |  |   | PRINCE GEORGES COUNTY MD.  |                                   |   |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| ANDREWS AFB  | MALCOLM GROW USAF MEDICAL CENTER   |  | SECRETARY   |  | Church                            |   |  |
| 13a. STATE   |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET ADDRESS               |   |  |
| MARYLAND   |  | PG   | CLINTON   |  | 9414 CHELTENHAM Avenue            |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |   |  |                                   |   |  |
| EMILIO CARPENITO (D)   |  | MARY Dorso (D)   |   |  |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS  |                                   |   |  |
| NO   |  | 018-20-6968  |   | CHARLES HOUSEWRIGHT 9414 CHELTENHAM Ave. CLINTON, MARYLAND   |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lung Cancer</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mo. |  |  |   |  |                                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>  |  |  |   |  |                                   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                                   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 29 Jun 1979, to 29 Jun 1979, that (I) (we) last saw the deceased alive on 29 Jun 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, so state.)   |  |  |   |  |                                   |   |  |
| 22b. SIGNATURE OF PHYSICIAN  |  | DEGREE   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                                   | 22c. DATE SIGNED 29 Jun 79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |  |                                   |   |  |
| SUSAN P. ABERNATHY, CAPT, USAF,  |  | MC   |   | MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB, MARYLAND 20331   |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |                                   | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |
| Burial   |  | Jul. 2, 1979   |   | Arlington Nat'l. Cem. Ft. Myer   |                                   | Arl. Va.  |  |
| 24. FUNERAL HOME   |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |                                   |   |  |
| Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, Md.  |  | JUN 2 1979   |   | Richard R. R. R.   |                                   |   |  |

1 2 3 4

|                |      |          |               |                           |
|----------------|------|----------|---------------|---------------------------|
| DATE           | TIME | LOCATION | STATUS        | REMARKS                   |
| APRIL 10, 1983 | 21   | WHITE    | MASSACHUSETTS | CONSTANCE PATRICIA HORTON |
| APRIL 10, 1983 | 21   | WHITE    | MASSACHUSETTS | CONSTANCE PATRICIA HORTON |
| APRIL 10, 1983 | 21   | WHITE    | MASSACHUSETTS | CONSTANCE PATRICIA HORTON |
| APRIL 10, 1983 | 21   | WHITE    | MASSACHUSETTS | CONSTANCE PATRICIA HORTON |
| APRIL 10, 1983 | 21   | WHITE    | MASSACHUSETTS | CONSTANCE PATRICIA HORTON |
| APRIL 10, 1983 | 21   | WHITE    | MASSACHUSETTS | CONSTANCE PATRICIA HORTON |
| APRIL 10, 1983 | 21   | WHITE    | MASSACHUSETTS | CONSTANCE PATRICIA HORTON |
| APRIL 10, 1983 | 21   | WHITE    | MASSACHUSETTS | CONSTANCE PATRICIA HORTON |
| APRIL 10, 1983 | 21   | WHITE    | MASSACHUSETTS | CONSTANCE PATRICIA HORTON |
| APRIL 10, 1983 | 21   | WHITE    | MASSACHUSETTS | CONSTANCE PATRICIA HORTON |

*Handwritten notes and signatures in the middle section of the document.*

*Handwritten notes and signatures at the bottom of the document.*





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use by the attending physician and completely filled in by the funeral director. Pages 3 and 4 should be detached for use by the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |         |  |                   |  |     |  |          |  |
|---|---------|--|-------------------|--|-----|--|----------|--|
| 1. FOR STATE REGISTRAR  |         | 2a. DATE OF DEATH  |                   | MONTH  | DAY | YEAR   | 2b. HOUR | P  |
| 1. DECEASED NAME (TYPE OR PRINT)  |         | FIRST  | MIDDLE            | LAST   |     |  | 06       | 06   |
| John Evelyn HUNT  |         |  |                   |  |     |  | 79       | 12:50  |
| 3 SEX   | 4. RACE | 5. DATE OF BIRTH   |                   | 6. AGE (IN YEARS LAST BIRTHDAY)  |     | IF UNDER 1 YEAR  |          | IF UNDER 24 HRS                                  |
| FEMALE  | Black   | 7-21-1918  |                   | 60   |     | MONTHS   |          | DAYS   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |     | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |          | MD.  |
| N.C.  |         | U.S.A.   |                   |  |     | PRINCE GEORGE'S COUNTY   |          |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |     | 12b. KIND OF BUSINESS OR INDUSTRY                              |          |  |
| CHEVERLY  |         | PRINCE GEORGE'S GENERAL HOSPITAL   |                   | Domestic   |     |  |          |  |
| 13a. STATE  |         | 13b. COUNTY  | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?   |     | 13e. STREET ADDRESS  |          |  |
| MD  |         | P.G.   | Farmington Hills  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |     | 907 Eastern Ave.   |          |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |                   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |     | 16b. SOCIAL SECURITY NO.                                       |          | 17. INFORMANT                                    |
| FIRST   |         | LAST   |                   |  |     |  |          | ADDRESS  |
| McCrone   |         | Unknown  |                   | No   |     | 244-39-5810  |          | Alice Rice 1501 13th Street 6th Floor Radon Hall |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |         | IMMEDIATE CAUSE (a)  |                   | DUE TO, OR AS A CONSEQUENCE OF (b)   |     | DUE TO, OR AS A CONSEQUENCE OF (c)                             |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |
| Probable Sepsis   |         |  |                   | CHRONIC RENAL FAILURE ON Postrenal Dialysis  |     |  |          | 6 months +                                       |
| 2500  |         |  |                   | Diabetes Mellitic  |     |  |          | 20+ years  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |  |                   |  |     |  |          |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   | 20a. AUTOPSY?  |     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |          |  |
|   |         |  |                   | YES <input type="checkbox"/> NO <input type="checkbox"/>   |     | YES <input type="checkbox"/> NO <input type="checkbox"/>       |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |         | 21b. TIME OF INJURY  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |     |  |          |  |
|   |         | HOUR A.M. MONTH DAY YEAR   |                   |  |     |  |          |  |
| 21d. INJURY OCCURRED  |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |                   | 21f. LOCATION  |     |  |          |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |  |                   | STREET   |     | CITY OR TOWN   |          | COUNTY   |
|   |         |  |                   |  |     |  |          | STATE  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/5, 1978, to 6/6, 1979, that (I) (we) lost saw the deceased alive on 6/5, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |         |  |                   |  |     |  |          |  |
| 22b. SIGNATURE  |         | DEGREE   |                   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |     | 22c. DATE SIGNED   |          |  |
| John E. Hunt MD   |         | MD   |                   |  |     | 6/6/79   |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |         | 22e. ADDRESS   |                   |  |     |  |          |  |
| STEVEN M. POLIAK MD   |         | 4700 AUTH PLACE  |                   | CAMP SPRING  |     |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY   |     | 23d. LOCATION  |          | STATE  |
|   |         | 6-12-79  |                   | Harmony  |     | Highland Park  |          | MD   |
| 24. FUNERAL DIRECTOR  |         | 25a. DATE REC'D. BY REGISTRAR  |                   | 25b. REGISTRAR'S SIGNATURE   |     |  |          |  |
| H. S. Moshier & Sons  |         | 4925   |                   | N. H. Brumby   |     | JUN 14 1979  |          |  |



05001 1/1

11/1/1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |  |   |  |  |  |
|--|--|---|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>MARY Elizabeth HURLBURT   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>05-25-79                        |   |  | 2b. HOUR<br>4:30PM <sub>M</sub>  |   |  |  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Cau.   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 14, 1923   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>55 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGE'S COUNTY MD.   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>CHEVERLY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PRINCE GEORGE'S HOSPITAL |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  |  |  |
| 13a. STATE<br>Maryland   |  |   | 13b. COUNTY<br>Charles   |   | 13c. CITY OR TOWN<br>Indian Head   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>24 Delta Place        |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert Weeks   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susan Riley           |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----       |   | 17. INFORMANT<br>ADDRESS<br>George A. Hurlburt same as 13                      |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION - ACUTE<br>410 -<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br>Diabetes Mellitus, Chronic Renal Failure   |  |   |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br>-  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>-                  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-1-19-79 to 5/25-19-79, that (I) (we) lost saw the deceased alive on 5/25-19-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Steven M Pollak MD   |  |   | DEGREE<br>MD   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br>5/26/79                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STEVEN M POLLAK MD  |  |   |  |   | 22e. ADDRESS<br>4700 AUTH PL. CAMP SPRINGS MD.                                 |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |   | 23b. DATE<br>5-29-79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Trinity Mem. Garden                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Waldorf, Charles, Md.                             |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Huntt Funeral Home Waldorf, Maryland   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>JUN 4 1979                                    |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]   |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |   |   |   | REG. NO. 15525  |   |
|---|---|---|---|---|---|
| 1. FOR STATE REGISTRAR  |   |   |   |   |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Hoyt Pleasant Hutchison</b>  |   |   | 2b. DATE OF DEATH MONTH DAY YEAR<br><b>6/28 1979</b>                                |   | 2b. HOUR<br><b>11:45</b> AM   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Sept 18 1899</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS                                    |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Pri. Georges</b> MD                      |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Laurel</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>15500 Claybourne Drive</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Real Estate</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Shopping Ctr.</b>   |
| 13a. STATE<br><b>Md.</b>  |   |   | 13b. COUNTY<br><b>Pri. Geo.</b>   | 13c. CITY OR TOWN<br><b>Laurel</b>  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Eduard Robert Hutchison</b>   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Flora May Ferrin</b>               |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>215-36-5590</b>  | 17. INFORMANT ADDRESS<br><b>Mrs Elva Hutchison - same</b>                           |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b><br><b>4390</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yr</b><br><b>10 yr</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>2</b>  |   |   |   |   |   |
| 19a. DATE OF OPERATION<br><b>29</b>   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>June 25</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>June 25</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                         |   |   |   |   |   |
| 22b. SIGNATURE<br><b>Robert S. McCeney M.D.</b>   |   |   |   | 22c. DATE SIGNED<br><b>6/28/79</b>  |   |
| 22d. PHYSICIAN'S NAME AND ADDRESS<br><b>ROBERT S. MCCENEY M. D.<br/>402 Main Street<br/>Laurel, Maryland 20810</b>  |   |   |   | 22e. ADDRESS  |   |
| 23a. BURIAL, CREMATION, REMOVAL (CITY)<br><b>Burial</b>   |   | 23b. DATE<br><b>July 1, 1979</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>1st Hill</b>                               |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Laurel Md</b>   |
| 24. FUNERAL DIRECTOR NAME<br><b>Donaldson Funeral Home</b>  |   | 25a. DATE OF RECORD BY REGISTRAR<br><b>JUL 2 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Robert S. McCeney</b>                            |   |

1 2 3 4 5 6 7 8 9 10 11 12

RECEIVED



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15526  
REG. NO.

|   |  |  |   |  |
|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Rose E. INTELLINI</b>  |  | 2a. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/><br><b>6-5 1979</b> |   | 2b. HOUR<br>AM <input checked="" type="checkbox"/> PM <input checked="" type="checkbox"/>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/><br><b>10-5-1928</b>       | 6. AGE IN YEARS<br>LAST 80 DAYS<br><b>50 YRS</b>                                    | 7. DATE PRONOUNCED DEAD<br>MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/><br><b>6-5 1979</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WASHINGTON, D. C.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges</b> MD                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lanham</b>  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Doctors' Hospital of Pr. Geo. Co.</b>   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. CITY OR TOWN<br><b>MONTGOMERY</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 13e. STREET ADDRESS<br><b>10228 CONOVER DRIVE</b>                                   |  |
| 14. FATHER'S NAME<br>FIRST <b>ALFONSO</b> MIDDLE <b>LEPRE</b> LAST <b>ANGELA</b>  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ANGELA</b> MIDDLE <b>GIAMPAGIA</b> LAST <b>GIAMPAGIA</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>  | 16b. SOCIAL SECURITY NO.<br><b>217-48-5975</b>   | 17. INFORMANT<br>ADDRESS<br><b>VIRGINIA MARAIO SAME AS 13 DAUGHTER</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Left intertrochanteric fracture</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)                  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Osteoporosis, Arteriosclerotic cerebro-cardiovascular disease</b>   |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>May 30, 1979</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>Stemming of intertrochanteric fracture</b>   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH  | 21b. TIME OF INJURY<br>HOUR <input checked="" type="checkbox"/> MIN <input checked="" type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/><br><b>11:55 P.M. May 25, 1979</b> | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Fell while walking</b>   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Villa Eva Home</b>   | 21f. LOCATION<br>STREET <b>3800 Lotspur Vista Rd.</b> CITY OR TOWN <b>Mt. Solon</b> COUNTY <b>Prince Georges</b> STATE <b>MD</b>   |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |  |
| ACTUAL SIGNATURE<br><b>Augusto P. Rodriguez</b>   | TITLE (SPECIFY)<br><b>M.D. Agutty</b>  |  | MEDICAL EXAMINER<br>DATE SIGNED <b>6-6-79</b>                                       |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Augusto P. Rodriguez</b>  | ADDRESS<br><b>5009 Rayburn Ct., Camp Springs, Md 20747</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>JUNE 8, 1979</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. OLIVET CEMETERY</b>   |   | 23d. LOCATION<br>CITY OR TOWN <b>WASHINGTON, D. C.</b> COUNTY <b>DC</b> STATE <b>DC</b>  |
| 24. FUNERAL DIRECTOR<br>NAME <b>FRANCIS J. COLLINS</b><br>ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 12 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |



NO. 10  
VANDERBILT

WASHINGTON, D. C. U.S.A.

RECEIVED

10000 CONOVER DRIVE

X

SILVER SPRING

WASHINGTON

MARVINO

CLARK

AMERICA

TYPE

ALFONSO

DAUGHTER SA E AS 13

VIRGINIA MARATO

217-44-5975

NO

THE UNITED STATES OF AMERICA

WASHINGTON, D. C.  
MARVINO  
ALFONSO  
AMERICA  
CLARK  
DAUGHTER  
VIRGINIA  
SILVER SPRING  
WASHINGTON  
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WASHINGTON, D. C.

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WASHINGTON, D. C.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15527

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |  |  |   |   |  |
|---|--|--|--|--|--|--|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Florence A. Jackson   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 30, 1979                   |  |  | 2b. HOUR<br>7:10 A.M.  |  |   |   |  |
| 3 SEX<br>Female   |  | 4 RACE<br>Negro  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>March 28, 1903  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>76 years YRS   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, D.C.  |  | 7b CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Prince Georges County MD.   |  |   |   |  |
| 10 CITY OR TOWN OF DEATH<br>Glenn Dale  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Glenn Dale Hospital |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic  |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |   |   |  |
| 13a STATE<br>District of Columbia   |  |  | 13b COUNTY<br>Washington   |  | 13c INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d STREET ADDRESS<br>3473 Holmead Place, N. W.                      |   |   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Alfred Bumbrey   |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Agnes Stanton          |  |  | ADDRESS<br>P. O. Box 621   |  |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>186-22-5491  |  | 17 INFORMANT<br>Martha B. Carter, Niece, Gordonsville, Va.                                     |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pulmonary Embolism COD<br>436-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) CVA with left hemiparesis & aphasia<br>(c) Hypertension<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                 |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 22, 1979 to June 30, 1979, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 30, 1979, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |   |  |
| 22b. SIGNATURE<br>James W. Wills, M.D.  |  |  | DEGREE<br>M.D.   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>June 30, 1979   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>James W. Wills, M.D.   |  |  | 22e. ADDRESS<br>Glenn Dale Hospital<br>Glenn Dale, Maryland 20769      |  |  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal   |  |  | 23b. DATE<br>6 Jul 79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>1132 You St., N.W., D.C.                                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Gordonsville, Virginia |   |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>W. Ernest Jarvis Co., Inc. Washington, D. C.   |  |  |  |  |  |  |  |   |   |  |

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Prompt action should be taken to return this certificate to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 7 9 1 5 5 2 8  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>CHARLES V. JAMISON  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>06-27-79   |  |  |  |
| 3. SEX<br>Male  |  |  |  | 7b. HOUR<br>7:30 PM  |  |  |  |
| 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Oct 11, 1903  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGE'S MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>CHEVERLY   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PRINCE GEORGE'S GENERAL HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Clerk/Ret   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Pa. DOT   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Penna   |  | 13c. CITY OR TOWN<br>Greene Greensboro   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>RD 1  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>John Jamison   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Leona Davis  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>unk  |  | 17. INFORMANT ADDRESS<br>Gladys Hubert (dau) Lanham, Maryland  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic bronchogenic carcinoma</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic obstructive lung disease</u>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>June 18</u> , 19 <u>79</u> , to <u>June 27</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>June 27</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Gerardo M. Gasch</u>   |  |  |  | DEGREE<br>MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                |  | 22c. DATE SIGNED<br>6/28/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GERARDO M. GASCH   |  |  |  | 22e. ADDRESS<br>6490 LANDOVER RD. LANDOVER MD  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>7/1/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Monongahela Hills  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Monongahela Greene Pa   |  |
| 24. FUNERAL DIRECTOR NAME<br>Francis Gasch's Sons, PA Hyattsville, Md.  |  |  |  | 25. DATE RECD. BY REGISTRAR<br>JUL 2 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Harry McCreedy</u>  |  |

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## Medical Examiner Notified &amp; Released

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |   |   |   |
|---|--|---|--|---|--|---|---|---|---|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 7 9 1 5 5 2 9<br>REG. NO.   |  |   |  |   |   |   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Carl J. Jernberg</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 24, 1979</b>  |   |   | 2b. HOUR<br><b>3:00A M</b>                                      |   |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 25, 1898</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kansas</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Pr. Geo. Co.</b> MD.                                 |   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pr. Geo. Gen. Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Security Officer</b>     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't.</b>         |   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |   |   |   |   |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>P.G.</b>  |  | 13c. CITY OR TOWN<br><b>Greenbelt</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>53-B Crescent Rd. Apt- 105</b>        |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Peter A. Jernberg</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Hilda Osburn</b>   |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W. I</b>  |  | 17. INFORMANT<br><b>Beatrice C. Jernberg</b>  |  | ADDRESS Address Same as<br>No# 13e.   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Pulmonary arrest</b><br><b>4409</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Chronic Heart Failure / Renal Failure</b> Years<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerosis</b> years                  |  |   |  |   |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Stroke</b>  |  |   |  |   |  |   |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/7</b> , 19 <b>77</b> , to <b>June</b> , 19 <b>79</b> , that (I) (we) (we) saw the deceased alive on <b>6-22</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |   |   |   |
| 22b. SIGNATURE<br><b>David S. Schachter</b> M.D.  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>6-25-79</b>  |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>David S. Schachter, M.D.</b>  |  |   |  |   | 22e. ADDRESS<br><b>115-Center Way Greenbelt, Md.</b>   |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>6-26-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood P.G. Md.</b>                         |   |   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 26 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Henry McCreedy</i>   |   |   |

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For more information, contact:

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE DIVISION OF VITAL RECORDS. TO REGISTRAR: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE DIVISION OF VITAL RECORDS.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |  |  |  |  |  |  | REG. NO. 15530  |  |
|--|--|----------------------|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>CATHERINE A. JOHNSON</b>   |  |                      |  |  |  | 2a. DATE KNOWN OF DEATH <b>6-13-79</b> |  | 2b. HOUR <b>9:45</b>   |  | 2c. DATE OF DEATH <b>6-13-79</b>  |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b> |  | 5. DATE OF BIRTH <b>11-18-10</b>   |  | 6. AGE (IN YEARS) <b>68</b>            |  | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.   |  | 8. DATE OF DEATH <b>6-13-79</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b>                        |  |
| 10. CITY OR TOWN OF DEATH <b>Mt. Rainer</b>  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4205 Eastern Ave.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Retail Store</b>                             |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Md.</b>   |  |                      |  | 13b. COUNTY <b>Prince George</b>   |  |  |  | 13c. CITY OR TOWN <b>Mt. Rainer</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME <b>Kenneth M Skinner</b>   |  |                      |  | 15. MOTHER'S MAIDEN NAME <b>Catherine Leyhan</b>   |  |  |  | 16. SOCIAL SECURITY NO. <b>577-01-8261</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |  |                      |  | 17. INFORMANT <b>Dtr.</b>  |  |  |  | 17. ADDRESS <b>Rockville, Md. Mrs Joyce Brown, 5006 Adrian St.,</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Certain release for Cardio Vascular disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |  |                      |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>Chronic Obstructive Pulmonary disease</b>  |  |                      |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>   |  |                      |  | M.D. <b>Deputy</b>   |  |  |  | DATE SIGNED <b>6-14-79</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez</b>  |  |                      |  | ADDRESS <b>5009 Rayburn Ct. Camp Springs Md 20746</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  | 23b. DATE <b>6/15/1979</b>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>   |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>JOSEPH GAWLER'S SONS INC.</b>   |  |                      |  | ADDRESS <b>5138 WIS. AVE., N. W. WASH., D. C. 20015</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 18 1979</b>   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>   |  |                      |  |  |  |  |  |  |  |   |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(V.R. A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15531  
REG. NO.

|  |         |  |                   |   |                    |
|--|---------|--|-------------------|---|--------------------|
| 1- FOR STATE REGISTRAR   |         | 2a. DATE KNOWN OF DEATH                                  |                   | 2b. HOUR  |                    |
| DECEASED NAME (TYPE OR PRINT)  |         | DATE ESTIMATED   |                   | HOUR  |                    |
| Daniel T.. Johnson Sr  |         | 6 15 19 79   |                   | 8:49  |                    |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR  | 8. IF UNDER 24 HRS |
| male   | black   | 9 Jul 1940   | 38 YRS.           |   |                    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                             |                   | 8. MARRIED  |                    |
| D.C.   |         | U.S.A.   |                   | NEVER MARRIED   |                    |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |                    |
| Cheverly   |         | Prince George Hospital                                   |                   | Truck Helper  |                    |
| 13a. STATE   |         | 13b. CITY OR TOWN  |                   | 13c. STREET ADDRESS   |                    |
| D.C.   |         | None   |                   | Washington  |                    |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                 |                   | 16. SOCIAL SECURITY NO.   |                    |
| Carl Johnson   |         | Mildred Viney  |                   | Unknown   |                    |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |         | 17. INFORMANT  |                   | 18. CAUSE OF DEATH  |                    |
| Yes  |         | Pauline Johnson (Wife)                                   |                   | Multiple Injuries   |                    |
| U.S. Army  |         | 8110 Allendale Dr. Landover, Md                          |                   | 8120  |                    |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?        |                   | 20. AUTOPSY?  |                    |
|  |         |  |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                    |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY                                      |                   | 21c. HOW INJURY OCCURRED  |                    |
|  |         | 8:21 AM 6/15 19 79                                       |                   | object driver of truck struck parked auto and fixed                 |                    |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |         | 21e. PLACE OF INJURY                                     |                   | 21f. LOCATION   |                    |
|  |         | street   |                   | 170 West Way, Greenbelt, Prince Geo Co, MD                          |                    |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |                   |   |                    |
| ACTUAL SIGNATURE   |         | TITLE (SPECIFY)  |                   | DATE SIGNED   |                    |
| Virginia L. Dolan  |         | Assistant  |                   | 6/16/79   |                    |
| EXAMINER'S NAME (TYPE OR PRINT)  |         | ADDRESS  |                   |   |                    |
| Virginia L. Dolan, M.D.  |         | 111 Penn Street, Baltimore, MD 21201                     |                   |   |                    |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY                                  |                    |
| Burial   |         | 6/20/79  |                   | Harmony Cemetery  |                    |
| 24. FUNERAL DIRECTOR   |         | 25a. DATE REC'D. BY REGISTRAR                            |                   | 25b. REGISTRAR'S SIGNATURE  |                    |
| Modern Funeral Home  |         | JUN 22 1979  |                   | [Signature]   |                    |
| 3821-14th St, N.W. Wash, D.C.  |         |  |                   |   |                    |



1 5 5 5 1

9 Jul 1950

Truck Harbor

Washington

Carl Johnson

Marine Johnson (Wife)  
3110 Alameda Dr. Berkeley, Ca

Unknown U.S. Army

Harvey Lowery

Robert Johnson  
3110 Alameda Dr. Berkeley, Ca

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 5 5 3 2

FOR  
1 - STATE  
REGISTRAR

REG. NO.

|  |  |                  |   |  |                       |   |  |  |  |                                  |  |
|--|--|------------------|---|--|-----------------------|---|--|--|--|----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MARY MIDDLE C. LAST JOHNSON |  |                  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06-18-1979   |  | 2b. HOUR<br>5.45 P.M. |   |  |  |  |                                  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>BLACK |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>SEPT. 22, 1934 |                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br>44 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  | 8. IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WAKEFIELD, VA.              |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES   |  |                       | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGE'S COUNTY MD. |                                  |  |
| 10. CITY OR TOWN OF DEATH<br>CHEVERLY                                    |  |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PRINCE GEORGE'S GENERAL HOSPITAL |  |                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEKEEPER   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>PVT.                          |                                  |  |

|   |  |  |  |
|---|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MARYLAND 13b. CITY OR TOWN B. G. 13c. CITY OR TOWN GLENARDEN 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 7910 TYLER STREET |  |  |  |
| 14. FATHER'S NAME<br>FIRST CHARLIE MIDDLE GAY LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST ELLA MIDDLE MAE LAST BOYKIN      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES) 229-48-1169 |  |
| 17. INFORMANT<br>ADDRESS GLENARDEN, MARYLAND<br>MR. LEON B. JOHNSON/HUSBAND/7910 TYLER STREET   |  |  |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u><br>430-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cerebral Artery Spasm</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Ruptured Berry Aneurysm</u> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|---|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION<br>6/14/79  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Ruptured Aneurysm  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |

22a. I certify that (1) (this hospital) attended the deceased from 6/12 19 79 to 6/18 19 79, that (1) (we) lost  
saw the deceased alive on 6/18 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (1) (we) (did) (did not) view the body after death.

|   |  |              |  |  |  |                             |  |
|---|--|--------------|--|--|--|-----------------------------|--|
| 22b. SIGNATURE<br><u>Robert Ruderman</u>                    |  | DEGREE<br>MD |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>6/19/79 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert Ruderman MD |  |              |  | 22e. ADDRESS<br>6301 GREENBELT Rd. College PK 20740  |  |                             |  |

|   |  |                            |  |  |  |  |  |
|---|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) BURIAL                   |  | 23b. DATE<br>JUNE 23, 1979 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>JOHNSON CEMETERY |  | 23d. LOCATION<br>CITY OR TOWN DENDRON, COUNTY SURRY STATE VIRGINIA |  |
| 24. FUNERAL DIRECTOR<br>NAME ROLLINS FUNERAL HOME, INC. 4339 HUNT PL. |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br>N.E. JUN 22 1979      |  | 25b. REGISTRAR'S SIGNATURE<br><u>Robert Ruderman</u>               |  |

SECRET



SECRET



BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15533

1- FOR  
STATE  
REGISTRAR

|   |                         |  |   |  |   |  |
|---|-------------------------|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Raymond Preston JOHNSON</i>  |                         |  | 2a. DATE KNOWN OF DEATH<br>EST. <i>6/29</i> 19 <i>79</i>                        |  | 2b. HOUR <i>AM</i>  |  |
| 3. SEX<br><i>Male</i>   | 4. RACE<br><i>Black</i> | 5. DATE OF BIRTH<br>MONTH <i>7</i> DAY <i>23</i> YEAR <i>12</i>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <i>66</i> YRS.                               | IF UNDER 1 YR.<br>MONTHS <i></i> DAYS <i></i>  | IF UNDER 24 HRS.<br>HOURS <i></i> MIN <i></i>   | 7. DATE PRONOUNCED DEAD<br><i>6/29</i> 19 <i>79</i>                      |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>D.C. Washington,</i>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Prince Georges</i> MD         |
| 10. CITY OR TOWN OF DEATH<br><i>Cheredy, Md</i>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Prince George</i> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><i>D.C.</i>   |                         |  | 13b. COUNTY<br><i>Washington</i>  | 13c. CITY OR TOWN<br><i>Washington</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><i>D.C. 3329 MLKJ Avenue S.E.</i>                 |
| 14. FATHER'S NAME<br>FIRST <i>Richard</i> MIDDLE <i>Johnson</i> LAST <i></i>  |                         |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Edna</i> MIDDLE <i>Wright</i> LAST <i></i> |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><i>Yes</i>   |                         | 16b. SOCIAL SECURITY NO.<br><i>578-05-8670</i>   |   | 17. INFORMANT (Son) 1803 Crosby Rd.<br><i>Ramon P. Johnson Hyattsville, MD.</i>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <i></i><br>(c) <i></i><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |                         |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |  |   |  |   |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Augusto P. Rodriguez</i>   |                         | TITLE (SPECIFY)<br>M.D. <i>Deputy</i> MEDICAL EXAMINER   |   | DATE SIGNED <i>6/29/79</i>   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>  |                         | ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md. 20031</i>   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial)</i>   |                         | 23b. DATE<br><i>7/5/79</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Lincoln Cemetery</i>  |   | 23d. LOCATION<br>CITY OR TOWN <i>Suitland, Maryland</i> COUNTY STATE     |
| 24. FUNERAL DIRECTOR<br>NAME <i>Johnson &amp; Jenkins</i> ADDRESS <i>716 Kennedy St, N.W.</i>   |                         |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>JUL 9 1979</i>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>History McBrady</i>                     |

08001 11

08001 11





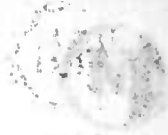
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 7 9 1 5 5 3 4<br>REG. NO.   |  |  |  |  |  |  |  |  |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST   |  | MIDDLE   |  | LAST   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR   |  | 2b HOUR<br>A M   |  |
| MAMIE  |  |   |  |  |  | JONES  |  | 06 07 79   |  | 7:00 M   |  |
| 3 SEX  |  | 4 RACE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN                                   |  |
| Female   |  | Negro   |  | 10- 04 14  |  | 64 YRS.  |  |  |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGE'S COUNTY MD.  |  |  |  |  |  |
| North Carolina   |  | U. S. A.  |  |  |  |  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  |  |  |  |  |
| CHEVERLY   |  | PRINCE GEORGE'S GENERAL HOSPITAL  |  |  |  |  |  |  |  |  |  |
| 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |
| Retired  |  | none  |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |  |  |  |  |  |  |  |  |
| 13a STATE  |  | 13b COUNTY  |  | 13c CITY OR TOWN   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e STREET ADDRESS   |  |  |  |
| Maryland   |  | Prince Geo. E. Riverdale  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 5409 67th Ave.   |  |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST  |  |  |  |  |  |  |  |  |  |
| Dave Wiggins   |  | Jessie Smith  |  |  |  |  |  |  |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17 INFORMANT ADDRESS   |  |  |  |  |  |  |  |
| NO   |  | N/A   |  | East Riverdale, Maryland<br>unavailable Ms. Lillie Dunston 5409 67th Ave.  |  |  |  |  |  |  |  |
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1 DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>1749<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Advanced Metastatic Carcinoma of the Breast</u><br>Aug. 1978<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>                                       |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>None</u> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22 I certify that (I) (this hospital) attended the deceased from <u>5-8-</u> 19 <u>79</u> , to <u>6-7-</u> 19 <u>79</u> , that (I) (we) last<br>saw the deceased alive on <u>6-7-</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  | 22b SIGNATURE<br><u>M. Baig</u>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br>6-7-79  |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e ADDRESS   |  |  |  |  |  |  |  |  |  |
| MAHMOUDULLAH BAIG  |  | 3750 FORT MEADE RD, LAUREL, MD  |  |  |  |  |  |  |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b DATE  |  | 23c NAME OF CEMETERY OR CREMATORY  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| Burial   |  | JUNE 13 '79   |  | Middlesex Cemetery   |  | Middlesex, North Carolina  |  |  |  |  |  |
| 24 FUNERAL DIRECTOR  |  | 24a ADDRESS   |  |  |  | 25a DATE REC'D. BY REGISTRAR   |  | 25b REGISTRAR'S SIGNATURE  |  |  |  |
| Tatney's   |  | 3831 Ga. Ave. N. W.   |  |  |  | JUN 18 1979  |  | <u>P. Baig</u>   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 7 9 1 5 5 3 5<br>REG. NO.  |  |   |  |   |  |   |  |   |  |
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a DATE OF DEATH MONTH DAY YEAR   |  | 2b HOUR                                       |  |
| VIOLA D. JONES   |  |  |  |   |  |   |  | 06 28 79  |  | 12:54p  |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS HOURS MIN                     |  |
| Female   |  | Black  |  | 10 19 98  |  | 80 YRS  |  |   |  |   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |   |  |
| Wash., DC  |  | USA  |  |   |  | Prince Georges County MD.   |  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                      |  | 12b KIND OF BUSINESS OR INDUSTRY              |  |
| Clinton  |  | SOUTHERN MARYLAND HOSPITAL CENTER  |  |   |  |   |  | Retired   |  | N/A   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a STATE  |  | 13b COUNTY  |  | 13c CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS                            |  |
| Maryland   |  | Prin. Geo.   |  | Lanham  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  | 8417 Hamilton St.                             |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |   |  |   |  |   |  |   |  |
| Joseph Dunnington  |  | UNKNOWN  |  |   |  |   |  |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)  |  | 17 INFORMANT  |  | ADDRESS   |  |   |  |   |  |
| NO   |  | 216-16-0576  |  | Frank Jones-Son-4413  |  | Bowie, Maryland<br>Olando Lane,   |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>   |  |  |  |   |  |   |  |   |  | 18b. SPECIFY NATURE OF DEATH (a) <u>Reins</u> |  |
| 486-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Heart Failure</u>  |  |  |  |   |  |   |  |   |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal Failure, Uremia</u>  |  |  |  |   |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><u>Renal Failure, Uremia</u>   |  |  |  |   |  |   |  |   |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/28</u> 19 <u>79</u> to <u>6/28</u> 19 <u>79</u> that (I) (we) last saw the deceased alive on <u>6/28</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE <u>R. M. Jones</u>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                         |  | 22c. DATE SIGNED <u>6/28/79</u>   |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>REP. M. S. Jones</u>  |  | 22e. ADDRESS <u>9235 25th Ave NW 20031</u>   |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>  |  | 23b. DATE <u>7/5/79</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Maryland National Park</u>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Laurel, Maryland</u>   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME <u>Stewart Funeral Home</u>  |  | 24b. DATE REC'D. BY REGISTRAR <u>JUL 9 1979</u>  |  | 24c. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |  |   |  |   |  |   |  |
| 4000   |  |  |  |   |  |   |  |   |  |   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR THE MEDICAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |               |  |   |  |   |  |  |  | REC. NO. 15536   |  |
|---|--|---------------|--|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |               |  |   |  | 7a. DATE KNOWN OF DEATH   |  | x June 6 4 1979  |  | 7b. HOUR M   |  |
| 1. DECEASED NAME (TYPE OR PRINT) JAMES D. KEA   |  |               |  |   |  | 2c. DATE PRONOUNCED DEAD  |  | June 6 4 1979  |  | 8:18 P M   |  |
| 2. SEX male   |  | 4. RACE black |  | 5. DATE OF BIRTH Nov. 30, 1943  |  | 6. AGE (IN YEARS) 35 YRS.   |  | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  |  | 7. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) No. Carolina  |  |               |  | 7b. CITIZEN OF WHAT COUNTRY? United States  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD |  |
| 10. CITY OR TOWN OF DEATH District Heights  |  |               |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince George's Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance  |  | 12b. KIND OF BUSINESS OR INDUSTRY Government                   |  |
| 13a. STATE Maryland   |  |               |  | 13b. COUNTY Prince George Dist. Hts.  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS 2415 Ramblewood Drive                      |  |
| 14. FATHER'S NAME James H. Kea  |  |               |  | 15. MOTHER'S MAIDEN NAME Nancy Lee Beamon   |  |   |  | 16. SOCIAL SECURITY NO. 238 66 0908  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes  |  |               |  | 16b. SOCIAL SECURITY NO. 1964-1966  |  | 17. INFORMANT Mother ADDRESS Nancy L. Kea Rt 2 Box 464 Rosehill, N.C.   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-cerebral injuries<br>8152<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. |  |               |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |  |
| 19a. DATE OF OPERATION  |  |               |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                 |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |               |  | 21b. TIME OF INJURY 7:17 P.M. 6 4 1979  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) location of motorcycle/fixed object collision |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |               |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) highway               |  | 21f. LOCATION Pennsylvania Ave. East of/Prince George's, Md.  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .                          |  |               |  |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE Margarita A. Korell  |  |               |  | M.D. Assistant  |  |   |  | DATE SIGNED 6/6/79   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.   |  |               |  | ADDRESS 111 Penn Street   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal   |  |               |  | 23b. DATE 6/8/79  |  | 23c. NAME OF CEMETERY OR CREMATORY Rosehill Funeral Home  |  | 23d. LOCATION CITY OR TOWN Rosehill,   |  | COUNTY No. Car.  |  |
| 24. FUNERAL DIRECTOR NAME ALEXANDER S. POPE-2617  |  |               |  | ADDRESS Washington, D.C.  |  | 25a. DATE REC'D. BY REGISTRAR JUN 13 1979   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR   |   | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 7 9 1 5 5 3 7<br>REG. NO.   |   |
|--|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Thomas P. Keane - Jr  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>6 25 79   |  | 2b. HOUR<br>11:38 AM  |   |
| 3. SEX<br>MALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH MONTH DAY YEAR<br>SEPT. 10 - 1936  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>42 YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGES MD.                                      |   |
| 10. CITY OR TOWN OF DEATH<br>BOWIE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3512 MAUREEN LANE |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CHIEF OF BRANCH |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>FED. GOVT. |
| 13a. STATE<br>MARYLAND   |   | 13b. COUNTY<br>P.G.   | 13c. CITY OR TOWN<br>BOWIE   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>THOMAS P. KEANE - SR  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>CHRISTINE BROADBACK   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |   | 16b. SOCIAL SECURITY NO.<br>077-28-9948   |  | 17. INFORMANT ADDRESS<br>SAME AS DECEASED<br>JUDITH A. KEANE. ITEMS 13                          |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>METASTATIC CANCER</u><br>1729<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>MALIGNANT MELANOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 YR.                       |   |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |   |   |  |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>12-10</u> , 19 <u>74</u> , to <u>6-25</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>5-22</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |  |   |   |
| 22b. SIGNATURE<br>Fred Cristofari MD   |   | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>6/25/79   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Fred C. Cristofari MD   |   | 22e. ADDRESS<br>3307 Superior Lane<br>Bowie MD 20715  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |   | 23b. DATE<br>6/28/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MT. OLIVET  |   |
| 23d. LOCATION CITY OR TOWN<br>WASHINGTON   |   | COUNTY<br>D.C.  |  | STATE   |   |
| 24. FUNERAL DIRECTOR NAME<br>W. W. CHAMBERS CO.  |   | ADDRESS<br>BLUEDALE   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 2 1979   |   |
| 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |   |   |  |   |   |



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |  |   |  |   |  |   |  |  |
|---|--|--|--|--|---|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LORENA J KEEGAN</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>6-24-79</b>                     |  |   | 2b. HOUR<br><b>10 PM</b>   |   |  |   |  |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPT 26, 1901</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WEST VIRGINIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>PRINCE GEORGES</b> MD.   |   |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>HYATTSVILLE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>CARROLL MANOR NURSING HOME</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. GOVT.</b>   |   |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>PRI GEO</b>  |  | 13c. CITY OR TOWN<br><b>ADELPHI</b>                         |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>9400 ADELPHI ROAD</b> |  |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HARRY KEEGAN</b>  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY TURNER</b>     |  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |   |  |   | 16b. SOCIAL SECURITY NO.<br><b>577-60-4195</b> |  |
| 17 INFORMANT<br><b>SISTER</b>   |  |  | ADDRESS<br><b>SILVER SPRING, MD.</b>                                   |  |   | 17<br><b>ALICE V. KEEGAN, 1111 UNIV. BLVD., WEST</b>   |   |  |   |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Shock state (septicemic)</b><br><b>5901</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Pyloroplasty, post, severe</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>6 weeks</b> |  |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 hours</b>   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Anterior wall Heart Disease; Osteoarthritis</b>   |  |  |  |  |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 26, 1977</b> to <b>June 24, 1979</b> , that (I) (we) last saw the deceased alive on <b>June 24, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                 |  |  |  |  |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>John F. Brennan M.D.</b>   |  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>24 June 79</b>  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN F. BRENNAN</b>   |  |  |  |  |   | 22e. ADDRESS<br><b>3415 HAMILTON ST., HYATTSVILLE, MD.</b>   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>6/26/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SILVER SPRING MONT MD.</b>                     |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>   |  |  |  |  |   | ADDRESS<br><b>500 UNIV. BLVD., WEST, SILVER SPRING, MD. 20901</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1979</b>  |   |  |  |

Page 3 of 3  
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Page 4 may be retained by the hospital or attending physician.  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be deposited for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 382-1234.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 15539  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 20. DATE OF DEATH MONTH DAY YEAR 6/23/79  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth B Keene  |  | 2b. HOUR 3:30   |  | 21. DATE OF DEATH MONTH DAY YEAR 6/23/79  |  | 2b. HOUR 3:30   |  |
| 3 SEX Female   |  | 4 RACE White  |  | 5. DATE OF BIRTH MONTH DAY YEAR 7 6 94  |  | 6 AGE (IN YEARS LAST BIRTHDAY) 84   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD   |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.  |  |
| 10. CITY OR TOWN OF DEATH Hyattsville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Hyattsville |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE MD  |  |   |  | 13b. CITY OR TOWN, P.G. Hyattsville   |  | 13c. STREET ADDRESS 2727-Nicholson St.  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST THOMAS BEAN  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUSIE RAWLINGS   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO  |  |   |  |
| 16b. SOCIAL SECURITY NO. 579-42-7840   |  | 17. INFORMANT COUSIN W. PERRY EARLY   |  | ADDRESS 10024 STEDWICK RD. GAITHERSBURG, MD.  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6/23/79  |  |   |  |
| 4140   |  |   |  | DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-sclerotic Heart Disease  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |  | DUE TO, OR AS A CONSEQUENCE OF (c) Generalized atherosclerosis  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/12/79, 19, to 6/23/79, 19, that (I) (we) lost saw the deceased alive on 6/12/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  | 22c. DATE SIGNED 6/23/79  |  |   |  |
| 22b. SIGNATURE   |  | DEGREE MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  | 22c. DATE SIGNED 6/23/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William F. Simpson MD  |  | 22e. ADDRESS 8106 N.H. Ave. Silver Spring Md 20903  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL   |  | 23b. DATE 6/26/79   |  | 23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY  |  | 23d. LOCATION CITY COUNTY STATE WASHINGTON, D.C.  |  |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS   |  | 25a. DATE REC'D. BY REGISTRAR JUN 25 1979   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| 500 UNIV. BLVD. W. SILVER SPRING, MD. 20901  |  |   |  |   |  |   |  |

MEDICAL CERTIFICATION

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HOMEWATER

PAVING

SPRINT

LEADS

THOMAS

270-42-7010

100 NORTH 10TH, N. C.

ROCK CREEK CHURCH

4/19/79

URGENT

FRANCIS J. COLLINS

100 NORTH 10TH, N. C. 270-42-7010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   | REG. NO. 15540  |  |
|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>Annie Kell  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>6 4 79  |   | 2b. HOUR<br>3:45 AM  |
| 3. SEX<br>Female  | 4. RACE<br>WHITE   | 5. DATE OF BIRTH MONTH DAY YEAR<br>5 23 84  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>94   |   | # UNDER 1 YEAR MONTHS DAYS<br># UNDER 24 HRS. HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>England  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George MD.                                       |   |  |
| 10. CITY OR TOWN OF DEATH<br>Forestville  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Reageny Nursing Home |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                      | 12b. KIND OF BUSINESS OR INDUSTRY<br>---                                  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>md 1PG  |  | 13b. CITY OR TOWN<br>Wash DC  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS<br>4340 Livingston Rd SE                              |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Robert Henry H eap   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Ann Walsh  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>---   | 17. INFORMANT ADDRESS<br>Brian Kelly Son Same as #13  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>586- IMMEDIATE CAUSE (a) Uremia<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-24-79, to 6-4-79, that (I) (we) last saw the deceased alive on 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |
| 22b. SIGNATURE<br>William Kent Furst  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED<br>6-4-79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>William K. Furst   |  | 22e. ADDRESS<br>9401 Indian Head Hwy, Oxon Hill, Md. 20022  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   | 23b. DATE<br>June 6, 1979  | 23c. NAME OF CEMETERY OR CREMATORY<br>Fort Lincoln Cem  |   | 23d. LOCATION CITY OR TOWN<br>Brentwood PG                                | STATE<br>Md  |
| 24. FUNERAL DIRECTOR NAME<br>Robt E Wilhelm   |  | ADDRESS<br>4308 Suitland Rd., Suitland, Md.   |   | DATE REC'D. BY REGISTRAR<br>JUN 6 1979                                    |  |

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Einmal mehr wird nicht alles

0001 Indian Head Wg., -Sun Hill, Ind., 50053



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH: 17  
(VR A15 ME (5))  
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                        |   |  |  |   |   |   |   |  |
|--|--|------------------------|---|--|--|---|---|---|---|--|
| 1- FOR STATE REGISTRAR   |  |                        |   |  |  |   |   |   |   |  |
| REG. NO. 15541   |  |                        |   |  |  |   |   |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>GLADYS E. KENNEDY</b>  |  |                        |   |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>6 23 1979</b>   |   | 2b. HOUR<br><b>5:30</b>   |   |  |
| 3 SEX<br><b>female</b>   |  | 4 RACE<br><b>white</b> |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec 30, 1910</b>                    |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.  |   | IF UNDER 1 YR. IF UNDER 24 HRS.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>South Carolina</b>   |  |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>PRINCE GEORGE'S COUNTY MD.</b>           |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Riverdale</b>  |  |                        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4803 Sheridan Street</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Apartment manager</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b> |  |
| 13a. STATE<br><b>Md</b>  |  |                        | 13b. COUNTY<br><b>Pro Georges</b>   |  | 13c. CITY OR TOWN<br><b>Riverdale</b>                            |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 13e. STREET ADDRESS<br><b>4803 Sheridan street</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William H Beers Sr</b>  |  |                        |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lula Mulikin</b>  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>   |  |                        |   | 16b. SOCIAL SECURITY NO.<br><b>224 48 3965</b>                               |  | 17. INFORMANT ADDRESS<br><b>Helen A Barnes 205 Delta Rd Knoxville Tennessee</b>   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carbon Monoxide Intoxication</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                        |   |  |  |   |   |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                        |   |  |  |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  |                        |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                        |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>1:50A.M. 6 23 1979</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>caught in housefire</b>   |   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  |                        |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>4803 Sheridan Street Riverdale, Maryland</b>  |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                        |   |  |  |   |   |   |   |  |
| ACTUAL SIGNATURE<br><i>[Signature]</i>   |  |                        |   | TITLE (SPECIFY)<br><b>Assistant</b>  |  |   |   | DATE SIGNED<br><b>6/23/79</b>   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Hormez R. Guard, M.D.</b>   |  |                        |   | ADDRESS<br><b>111 Penn Street</b>  |  |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  |                        | 23b. DATE<br><b>June 26, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft Lincoln Cemetery</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood Pro Georges Md.</b>            |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>F. Gasch's Sons P A Hyattsville, Md.</b>  |  |                        |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 28 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                    |   |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15542

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |   |   |  |   |   |
|--|--|---|--|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Margaret Rosaris Killeen</i>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>June 8 79</i>                |   |   | 2b. HOUR<br><i>12 35</i><br>M   |  |   |   |
| 3. SEX<br><i>FEMALE</i>  |  | 4. RACE<br><i>WHITE</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Apr 7 1889</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>90</i>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br>IF UNDER 24 HRS<br>HOURS MIN  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Pt. Geo.</i> MD.                                     |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><i>CLINTON</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>6406 HORSESHOE RD</i> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>HOUSEWIFE</i>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>AT HOME</i>   |   |
| 13a. STATE<br><i>MD</i>  |  | 13b. COUNTY<br><i>PG</i>  |  | 13c. CITY OR TOWN<br><i>Clinton</i>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>6406 Horseshoe Rd</i>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Michael Maughan</i>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Agnes Lynch</i> |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b. SOCIAL SECURITY NO.<br><i>170-09-3862</i>                         |   |   | 17. INFORMANT<br>ADDRESS<br><i>MARY ROWLAND DAUGHTER - ALIVE</i>                                |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i><br><i>4149</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Atherosclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Coronary Artery Disease</i><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>Chronic Lung Disease</i> |  |   |  |   |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>10 19</i>        |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><i>N/A</i>    |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1970</i> , 19 <i>79</i> , to <i>8 June 1979</i> , that (I) (we) last saw the deceased alive on <i>6 June 1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |  |   | 22b. SIGNATURE<br><i>Rene Grace MD</i> DEGREE   |
| 22c. DATE SIGNED<br><i>8 June 79</i>   |  |   |  |   |   |   |  |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Rene Grace MD</i>   |
| 22e. ADDRESS<br><i>Clinton, MD</i>   |  |   |  |   |   |   |  |   | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |

MEDICAL CERTIFICATION

|  |  |                             |  |  |  |   |  |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>BURIAL</i>                |  | 23b. DATE<br><i>6-11-79</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>ST. JOHN'S EVANGELIST</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>FOREST BLVD MD</i> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>G.P. KALAS 6160 OXON HILL RD.</i> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 11 1979</i>                |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

2000 100



RECEIVED



1000 100

## MEDICAL EXAMINER NOTIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

DHMM-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 15543

REG. NO.

|  |  |  |  |                 |  |
|--|--|--|--|-----------------|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | 2b. HOUR        |  |
| DECEASED NAME (TYPE OR PRINT)  |  | MONTH DAY YEAR   |  | A M             |  |
| FIRST MARY   |  | 06 24 79   |  | 7:15            |  |
| MIDDLE R.  |  |  |  |                 |  |
| LAST KIMBLE  |  |  |  |                 |  |
| 3 SEX  | 4 RACE   | 5. DATE OF BIRTH   | 6 AGE (IN YEARS LAST BIRTHDAY)                                 | IF UNDER 1 YEAR |  |
| FEMALE   | NEGRO  | MONTH DAY YEAR   | 67 YRS.  | IF UNDER 24 HRS |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  | MONTHS DAYS HOURS MIN.   |                 |  |
| LOUISIANA  | USA  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |                 |  |
| 10 CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |                 |  |
| CHEVERLY   | PRINCE GEORGE'S GENERAL HOSPITAL   | PRINCE GEORGE'S COUNTY MD.   |  |                 |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |                 |  |
| SEAMSTRESS   |  |  |  |                 |  |
| 13a. STATE   | 13b. CITY OR TOWN  | 13c. INSIDE CITY LIMITS?   | 13d. STREET ADDRESS  |                 |  |
| Md.  | P.G.   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 10218 Prince Pl.   |                 |  |
| 14 FATHER'S NAME   | 15 MOTHER'S MAIDEN NAME  |  |  |                 |  |
| FIRST MIDDLE LAST  | FIRST MIDDLE LAST  |  |  |                 |  |
| CHARLIE  | RANSOM   | ELNORA MALONE  |  |                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  | 16b. SOCIAL SECURITY NO.   | 17 INFORMANT ADDRESS   |  |                 |  |
| No   | 437-40-8023  | Mary O. Roach 10218 Prince Pl. Largo, Md.  |  |                 |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.   |  |  |  |                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) ① Coronary heart disease - acute   |  |  |  |                 |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) MF + cardiogenic shock  |  |  |  |                 |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) ② H.C.U.D.  |  |  |  |                 |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |                 |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                 |  |
|  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |                 |  |
|  | P.M. 19  |  |  |                 |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |                 |  |
|  |  |  |  |                 |  |
| 22a. certify that (I) (this hospital) attended the deceased from 6-23-19-79 to 6-24-19-79, that (I) (we) lost saw the deceased alive on 6-24-19-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |                 |  |
| 22b. SIGNATURE   | DEGREE   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED   |                 |  |
| H. A. Molavi   |  |  | 6.24.79  |                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  | 22e. ADDRESS   |  |  |                 |  |
| H. A. Molavi   | 6005 Land over Rd, Cheverly, Md.   |  |  |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |                 |  |
| BURIAL   | 6/28/79  | LINCOLN MEMORIAL   | 8 SUTTLAND MD.   |                 |  |
| 24 FUNERAL DIRECTOR NAME   | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR                                  |                 |  |
| MORROW & WOODFORD, INC.  | 1622 11th. St. NW Wash., D.C.  |  | JUN 28 1979  |                 |  |

3501

U.S. GOVERNMENT PRINTING OFFICE

U.S. GOVERNMENT PRINTING OFFICE

70

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 1 5 5 4 4  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Betty</b><br><i>Betty</i>  |  | MIDDLE<br><b>Leora</b>   |  | LAST<br><b>Kincaid</b><br><i>KINCAID</i>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 8 79</b>  |  | 2b. HOUR<br><b>11:40 AM</b>  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>white</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov 12, 1906</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Oklahoma</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>        |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pr. Geo. Gen. Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Supervisor Dept of Navy</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Ma.</b>   |  | 13b. COUNTY<br><b>P.G.</b>   |  | 13c. CITY OR TOWN<br><b>Hillcrest Hgts</b>   |  | 13d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                    |  | 13e. STREET ADDRESS<br><b>3001 Branch Ave</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward A. Kincaid</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Maggie Dickey</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Hillcrest Hgts, Md. 20031</b><br><b>Elizabeth B. Steele-neice 3001 Branch Ave</b>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Respiratory Failure</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Carcinoma Lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Polycystic kidneys with End-Stage Renal Failure</b>   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 1975</b> , to <b>6/8/79</b> , that (I) (we) lost saw the deceased alive on <b>6/8/79</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Jaswinder Sidhu</i>  |  |  |  | DEGREE<br><i>MD.</i><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>6/8/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JASWINDER SIDHU, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>4700 AUTH PLACE, CAMP SPRINGS, MD.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>6-9-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b>                                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 15 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John H. Brady</i>  |  |  |  |



No  
 None  
 Edward A. Kincaid  
 447-GF-1044 Elizabeth R. Steele-nee 3001 Branch Ave  
 Hillcrest Estate, Md. 20031  
 Maggie Dickey

Md.  
 P.G.  
 Hillcrest Estate

Cheverly  
 Pr. Geo. Gen. Hospital

Oklahoma  
 USA  
 white  
 Nov 13, 1905

Betty  
 Leonard

Kincaid

Cremation  
 6-9-76  
 Lee's Crematory  
 Washington, D.C.

Lee Funeral Home 300-4th St. W. & 4th D.C.

2000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15545  
REG. NO.

|   |         |  |                                    |  |                             |   |                             |                          |       |       |      |          |
|---|---------|--|------------------------------------|--|-----------------------------|---|-----------------------------|--------------------------|-------|-------|------|----------|
| 1. FOR STATE REGISTRAR  |         | 1. DECEASED NAME<br>(TYPE OR PRINT)  |                                    | FIRST  | MIDDLE                      | LAST  | 2a. DATE KNOWN OF DEATH     | ESTI-MATED               | MONTH | DAY   | YEAR | 2b. HOUR |
|   |         | James Harold King, Jr.   |                                    |  |                             |   |                             |                          | 6     | 30    | 1979 | M        |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH<br>MONTH DAY YEAR   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY | 7. IF UNDER 1 YR.<br>MONTHS  | 8. IF UNDER 24 HRS.<br>DAYS | 9. IF UNDER 24 HRS.<br>HOURS  | 10. IF UNDER 24 HRS.<br>MIN | 2c. DATE PRONOUNCED DEAD | MONTH | DAY   | YEAR | 2d. HOUR |
| Male  | White   | May 28, 1957   | 22 YRS.                            |  |                             |   |                             | 6                        | 30    | 1979  | 3:53 | M        |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                             |                          |       |       |      |          |
| Maryland  |         | U.S.A.   |                                    |  |                             | Prince George's County, MD  |                             |                          |       |       |      |          |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                             | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                             |                          |       |       |      |          |
| Cheverly  |         | Prince George's Gen. Hospital (DOA)  |                                    | Manager  |                             | Grand Union   |                             |                          |       |       |      |          |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |         | 13b. CITY OR TOWN  |                                    | 13c. INSIDE CITY LIMITS?   |                             | 13d. STREET ADDRESS   |                             |                          |       |       |      |          |
| Maryland  |         | Prince Georges   |                                    | Hyattsville  |                             | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                             | 6800 Goodwin Street      |       |       |      |          |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |                                    |  |                             |   |                             |                          |       |       |      |          |
| James H. King   |         | Betty Skocich  |                                    |  |                             |   |                             |                          |       |       |      |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT ADDRESS  |                             |   |                             |                          |       |       |      |          |
| No  |         | 212 76 9793  |                                    | Betty J. Ocker Same as # 13 (Mother)   |                             |   |                             |                          |       |       |      |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |                                    |  |                             |   |                             |                          |       |       |      |          |
| PART I DEATH WAS CAUSED BY:   |         |  |                                    |  |                             |   |                             |                          |       |       |      |          |
| IMMEDIATE CAUSE (a) Multiple injuries   |         |  |                                    |  |                             |   |                             |                          |       |       |      |          |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |                                    |  |                             |   |                             |                          |       |       |      |          |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |         |  |                                    |  |                             |   |                             |                          |       |       |      |          |
| (b) DUE TO, OR AS A CONSEQUENCE OF  |         |  |                                    |  |                             |   |                             |                          |       |       |      |          |
| (c)   |         |  |                                    |  |                             |   |                             |                          |       |       |      |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |  |                                    |  |                             |   |                             |                          |       |       |      |          |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                                    | 20. AUTOPSY?   |                             |   |                             |                          |       |       |      |          |
|   |         |  |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                             |   |                             |                          |       |       |      |          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                             |   |                             |                          |       |       |      |          |
|   |         | 2:30xx 6 30 1979   |                                    | passenger in auto/fixed object impact  |                             |   |                             |                          |       |       |      |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                                    | 21f. LOCATION STREET   |                             | CITY OR TOWN  |                             | COUNTY                   |       | STATE |      |          |
|   |         | STREET   |                                    | Central Ave.   |                             | Largo   |                             | P.G.                     |       | Md    |      |          |
| 22. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |                                    |  |                             |   |                             |                          |       |       |      |          |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)  |                                    | DATE SIGNED  |                             |   |                             |                          |       |       |      |          |
|   |         | M.D. Deputy Chief  |                                    | 7/1/79   |                             |   |                             |                          |       |       |      |          |
| EXAMINER'S NAME (TYPE OR PRINT)   |         | ADDRESS  |                                    |  |                             |   |                             |                          |       |       |      |          |
| Thomas D. Smith, M.D.   |         | 111 Penn St. Balto., MD.   |                                    |  |                             |   |                             |                          |       |       |      |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE  |                                    | 23c. NAME OF CEMETERY OR CREMATORY   |                             | 23d. LOCATION CITY OR TOWN  |                             | COUNTY                   |       | STATE |      |          |
| Burial  |         | 7/3/79   |                                    | Ft. Lincoln Cemetery   |                             | Brentwood   |                             | P.G.                     |       | Md.   |      |          |
| 24. FUNERAL DIRECTOR  |         |  |                                    | 25a. DATE REC'D. BY REGISTRAR  |                             | 25b. REGISTRAR'S SIGNATURE  |                             |                          |       |       |      |          |
| Francis Gasch's Sons Funeral Home, P.A.<br>Hyattsville, Maryland  |         |  |                                    | JUL 5 1979   |                             | History, Maryland   |                             |                          |       |       |      |          |

1 2 3 4 5

May 24, 1907

U.S.A.

England

Grand Union

Wagon

1800 London Street

X

British Empire

England

London

Water

Ship

U.S.

London

Letter 1, 1000-1000 on 17. 17. 1907

1000-1000

10

London, England  
British Empire  
1800 London Street  
Wagon  
Grand Union



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 7 9 1 5 5 4 6  |  | REG. NO.  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>SAMUEL KRAVITZ  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6 30 79  |  | 2b. HOUR<br>10:05 PM   |  |  |  |
| 3 SEX<br>Male   |  | 4 RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>January 1, 1896   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Russia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince Georges MD.                           |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Greenbelt  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GREENBELT CONVALESCENT CENTER |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Merchant         |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Men's Clothing  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |  |  | 13b. COUNTY<br>Prince Georges   |  | 13c. CITY OR TOWN<br>Hyattsville   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Eli Kravitz   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Leah Unknown   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>578-46-6071   |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Eleanore Fleisher Same as No. 13   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonitis</u><br>4349<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Aspiration of food and gastric contents</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Left Middle cerebral infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>days<br>days<br>2 months   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Hypertension, benign prostatic hypertrophy</u>  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>4/22</u> 19 <u>79</u> , to <u>6/30</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/29</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Byrl D. Johnson</u>  |  |  |  | DEGREE<br>MD<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  | 22c. DATE SIGNED<br>7/1/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BYRL D. JOHNSON  |  |  |  | 22e. ADDRESS<br>4404 Queensbury Rd. Riverdale, Md 20740   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>7/2/1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>King David Memorial Garden  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Falls Church, Virginia                 |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Donald M. Stein Hebrew Memorial F.H.<br>232 Carroll Street, N. W. Washington, D. C.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 5 1979   |  |  |  |  |  |

C. B. C. F. C. C.





FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15547

|   |  |   |  |   |   |  |   |  |  |
|---|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DAVID GEORGE KYLE</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>JUNE 20, 1979</b>            |   |   | 2b. HOUR<br><b>11:15A<sub>M</sub></b>  |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>FEB 1, 1923</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>56</b>   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wyoming</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's MD.</b>                         |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lanham</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Doctors' Hospital of Pr. Geo. Co.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Professor Univ.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>of Md.</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |   |  |   |  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>P.G.</b>  |  | 13c. CITY OR TOWN<br><b>New Carrollton</b>  |   | 13d. INSIDE CITY LIMITS?<br><b>YES</b> NO <input type="checkbox"/>                         |   | 13e. STREET ADDRESS<br><b>5450 85th Ave #101</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>David Frederick Kyle</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carrie Bishop</b>                             |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes WWII</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>524-14-8262</b>                         |   | 17. INFORMANT<br><b>New Carrollton, Md. 20784</b><br><b>Mary Ann Kyle-wife 5450-85th Ave #101</b> |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Myocardial infarction</b><br>(b) <b>Arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
|   |  |   |  |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I<br><b>Hypertension, Chronic obstructive lung disease</b>  |  |   |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>6/20/79</b>  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>L</b>           |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                    |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 15, 1979</b> , to <b>6/20/79</b> , that (I) (we) lost saw the deceased alive on <b>6/20/79</b> , 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>DR. RAO</b> MD   |  |   | 22c. DATE SIGNED<br><b>6/20/79</b>                                     |   |   |  |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. S. RAO</b>   |  |
| 22e. ADDRESS<br><b>Doctors Hospital (301) 867-7700</b>  |  |   |  |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>   |  |   | 23b. DATE<br><b>6-21-79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>                                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Lee Funeral Home 300-4th Street N.E. Wash. D.C. 20002</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 21 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>                 |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



Male

White

Feb 1, 1927

50

Wyoming

USA

x

MA

P.O.

New Carrollton

2450 82nd Ave #101

David Frederick Kyle

Genie Bishop

Yes Will

24-14-828

Mary Ann Kyle-wife 2450-82nd Ave #101

New Carrollton, MA 20000

Operation

6-21-72

Lee's Crematory

Washington, D.C.

Lee Funeral Home 300-14th Street N.E. Wash, D.C.



1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

|                                  |        |        |        |
|----------------------------------|--------|--------|--------|
| DECEASED NAME<br>(TYPE OR PRINT) | FIRST  | MIDDLE | LAST   |
|                                  | Oliver | P.     | LASLEY |

|                               |   |      |          |
|-------------------------------|---|------|----------|
| 2a. DATE KNOWN<br>OF<br>DEATH | <input checked="" type="checkbox"/> MONTH<br><input type="checkbox"/> DAY | YEAR | 2b. HOUR |
| ESTI-<br>MATED                | 6-8   | 1979 |          |

|                       |                         |   |  |  |  |   |  |  |  |
|-----------------------|-------------------------|---|--|--|--|---|--|--|--|
| 1. SEX<br><i>Male</i> | 2. RACE<br><i>Black</i> | 3. DATE OF BIRTH<br>MONTH <i>1</i> DAY <i>21</i> YEAR <i>1971</i> | 4. AGE (IN YEARS)<br>LAST BIRTHDAY<br>YEARS <i>1</i> | IF UNDER 1 YR.<br>MONTHS <i>1</i> DAYS <i>21</i> |  | IF UNDER 24 HRS.<br>HOURS <i>1</i> MIN. <i>21</i> |  | 5. DATE PRONOUNCED<br>MONTH <i>6</i> DAY <i>9</i> YEAR <i>1971</i> | 6. TIME PRONOUNCED<br>HOUR <i>7</i> MIN. <i>21</i> |
|-----------------------|-------------------------|---|--|--|--|---|--|--|--|

|   |                              |   |                                      |
|---|------------------------------|---|--------------------------------------|
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| Don Lucks                                 | United States                |   | Bowie Treogers                       |

|                           |  |   |                                     |
|---------------------------|--|---|-------------------------------------|
| 11a CITY OR TOWN OF DEATH | 11b NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE) | 12b KIND OF BUSINESS<br>OR INDUSTRY |
| Mitchellville             | 3600 Burlington Drive  | Chief of Police   | Govt.                               |

|            |  |                |                   |   |                     |
|------------|--|----------------|-------------------|---|---------------------|
| 13a. STATE |  | 13b. COUNTY    | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS |
| Md.        |  | Prince Georges | Mitchellville     |   | 3600 Birlough Drive |

|  |  |
|--|--|
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Richard Lester | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Dena Hunter |
|--|--|

|   |   |               |   |
|---|---|---------------|---|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) | 17. INFORMANT | ADDRESS                                       |
| yes   | 1943-1962   | 400-22-4925   | Wilhelmina P. Hasley-wife<br>same as item 13E |

|   |  |
|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY:   |  |
| IMMEDIATE CAUSE (a) <u>Cirrhosis secondary to alcohol disease</u>         |  |

|   |  |  |  |
|---|--|--|--|
| <p>4392</p> <p>Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u>.</p> | <p>(a) _____</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> |  |  |
|   | <p>(b) _____</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> |  |  |
|   | <p>(c) _____</p>                                       |  |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

|                        |   |  |
|------------------------|---|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY?   |
|                        |   | YES <input type="checkbox"/> NO <input type="checkbox"/> |

|  |                          |   |
|--|--------------------------|---|
| 21a. EXTERNAL CAUSE WAS                              | 21b. TIME OF INJURY      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| UNDERLYING <input type="checkbox"/> OR               | HOUR A.M. MONTH DAY YEAR |   |
| CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | P.M. 19                  |   |

|       |  |  |                         |              |        |       |
|-------|--|--|-------------------------|--------------|--------|-------|
| MEDIC | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.) | 21f. LOCATION<br>STREET | CITY OR TOWN | COUNTY | STATE |
|       |  |  |                         |              |        |       |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE James P. Rodriguez MD TITLE (SPECIFY) MD DATE SIGNED 6-9-79  
M.D. MD MEDICAL EXAMINER

EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez ADDRESS 5009 Bayview Ct., Camp Springs

|  |              |                                    |                               |        |           |
|--|--------------|------------------------------------|-------------------------------|--------|-----------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) | 23b. DATE    | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION<br>CITY OR TOWN | COUNTY | STATE     |
| Burial                                       | June 13 1979 | Hillcrest Cemetery                 | Hoboskie                      | N.C.   | no 2nd 31 |

|   |  |   |   |
|---|--|---|---|
| 24 FUNERAL DIRECTOR<br>NAME <u>Doyle's Funeral Home, Inc.</u> ADDRESS <u>4339 Hunt Pl. N.E.</u> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b> | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony McCreedy</u> |
|---|--|---|---|

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

3501  
DHMH-17 20M 1/73  
(VR AT5 ME (5))

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |              |   |   |  |  |  |  |   | REG. NO. 15549   |   |  |
|--|--|--------------|---|---|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) Thomas Alan Lease  |  |              |   |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED  |  | MONTH DAY YEAR 6 30 19 79                                    |   | 2b. HOUR M 6:00A   |   |  |
| 3 SEX Male   |  | 4 RACE White |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR Dec. 4, 1954                               |  | 6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS.  |  | IF UNDER 1 YR. MONTHS DAYS                                   |   | IF UNDER 24 HRS. HOURS MIN.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina   |  |              | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.      |  |   |  |
| 10. CITY OR TOWN OF DEATH Beltsville   |  |              | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sunnyside Rd at Railroad Crossing |   |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter |  | 12b. KIND OF BUSINESS Painting Contractor |  |
| 13a. STATE Maryland  |  |              |   |   |  | 13b. COUNTY Prince Georges   |  | 13c. CITY OR TOWN Hyattsville                                |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME Elmer L. Lease   |  |              |   |   |  | 15. MOTHER'S MAIDEN NAME Shirley Jean denHartog  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO, OR UNKNOWN) No   |  |              |   | 16b. SOCIAL SECURITY NO. 215 62 4508  |  |  |  | 17. INFORMANT ADDRESS Shirley J. Lease Same as # 13 (Mother) |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple injuries<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF           |  |              |   |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |              |   |   |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |              |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |  |  |  |  |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |              |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:40xx 6 30 19 79                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of auto struck by train   |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |              |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) railroad crossing |  | 21f. LOCATION STREET Sunnyside Rd.   |  | CITY OR TOWN Beltsville, P.G.                                |   | COUNTY STATE MD  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . |  |              |   |   |  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE Thomas D. Smith, M.D.   |  |              |   | TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER                            |  |  |  | DATE SIGNED 6/30/79  |   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.  |  |              |   | ADDRESS 111 Penn St. Balto., MD.  |  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial   |  |              |   | 23b. DATE 7/3/79  |  | 23c. NAME OF CEMETERY OR CREMATORY George Washington Cem.  |  | 23d. LOCATION CITY OR TOWN Hyattsville                       |   | COUNTY STATE P.G. Md.  |   |  |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland   |  |              |   |   |  | 25a. DATE REC'D. BY REGISTRAR JUL 5 1979   |  | 25b. REGISTRAR'S SIGNATURE                                   |   |  |   |  |

1 2 3 4 5

Dec. 1, 1931

North Carolina

Editor  
The Raleigh News and Observer

Dear Sir:

Enclosed for you are

2

three copies of the

following

copy of the

North Carolina

State

Report

1.

Enclosed

for your information, I have also enclosed a copy of the

report of the

State

Yours

Very

Respectfully

George Washington Carver

WVVO

Editor

Enclosed for you are three copies of the following report of the North Carolina State Report

TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |                                 |   |  |  |   |   |
|--|---|---|---------------------------------|---|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   |   | 2a. DATE OF DEATH               |   |  | 2b. HOUR                                   |   |   |
| JUNG MOOK LEE  |   |   | 06-09-79                        |   |  | 5:35AM                                     |   |   |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY) |   |  | 7. IF UNDER 1 YEAR                         |   |   |
| Male   | Korean  | 1 29 1908   | 71 YRS                          |   |  | MONTHS DAYS HOURS MIN.                     |   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                     |  |   |   |
| Korea  | Korea   |   |                                 |   | PRINCE GEORGES MD.                                       |  |   |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                                 | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                 |   |
| CHEVERLY   | PRINCE GEORGES GENERAL HOSPITAL   |   |                                 | Ret. Clerk  |  |  | Const. Co.  |   |
| 13a. STATE   |   | 13b. COUNTY   | 13c. CITY OR TOWN               | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS                                      |  |   |   |
| Md.  |   | Pr. Geo.  | Kent Village                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 6707 - West Forrest Rd.                                  |  |   |   |
| 14. FATHER'S NAME  |   |   | 15. MOTHER'S MAIDEN NAME        |   |  |  |   |   |
| Dong Hwan Lee  |   |   | Joo Nam Hong                    |   |  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |   |   | 16b. SOCIAL SECURITY NO.        |   |  | 17. INFORMANT ADDRESS                      |   |   |
| No   |   |   | 527-67-7299                     |   |  | Sang Hwa Lee (above address)               |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u><br>436-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertension, essential</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                 |   |   |                                 |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |   |   |                                 |   |  |  |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                 |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH? |   |
|  |   |   |                                 |   | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>          |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                                 | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |   |   |                                 |   |  |  |   |   |
| 22b. SIGNATURE   |   |   |                                 | DEGREE  |  |  | 22c. DATE SIGNED  |   |
| Dusan Laid   |   |   |                                 | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   |   |                                 | 22e. ADDRESS  |  |  |   |   |
| DUSAN LASS DA  |   |   |                                 | 6201 greenbelt Rd. Coll. Plk  |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE   |                                 | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |   |
| Burial   |   | 6/12/1979   |                                 | Ft. Lincoln Cem.  |  | Brentwood Pr. Geo. Md.                     |   |   |
| 24. FUNERAL DIRECTOR<br>NAME   |   |   |                                 | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR              |   | 25b. REGISTRAR'S SIGNATURE                      |
| Nalley's F.H. Inc.   |   |   |                                 | Mt. Rainier, Md.  |  | JUN 18 1979                                |   | Henry McCreedy                                  |

0 2 2 1 8 1

ESTON

2007-10-25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

added info #534 8/16/79 gj

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15551

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |                          |  |                     |     |            |          |
|--|--|--|--|---|--|---|--|--------------------------|--|---------------------|-----|------------|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | 2a. DATE OF DEATH        |  | MONTH               | DAY | YEAR       | 2b. HOUR |
| MALE   |  |  |  |   |  | LEONARD   |  | 5                        |  | 21                  | 79  | 7:20AM     |          |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                      |  | IF UNDER 1 YEAR          |  | IF UNDER 74 HRS     |     |            |          |
| MALE   |  | BLACK  |  | MONTH DAY YEAR  |  |   |  | MONTHS                   |  | DAYS                |     | HOURS MIN. |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |                          |  |                     |     |            |          |
| Maryland   |  | USA  |  |   |  | PRINCE GEORGES MD   |  |                          |  |                     |     |            |          |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |   |  |                          |  |                     |     |            |          |
| CHEVERLY   |  | PRINCE GEORGES GENERAL HOSP  |  |   |  |   |  |                          |  |                     |     |            |          |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? |  | 13e. STREET ADDRESS |     |            |          |
| Maryland   |  | Prince George  |  | Landover  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                          |  | 2334 Virginia Ave   |     |            |          |
| 14 FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                          |  |                     |     |            |          |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |   |  |   |  |                          |  |                     |     |            |          |
| Odell  |  | Leonard  |  | Cheryl Ann Smith  |  |   |  |                          |  |                     |     |            |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17 INFORMANT  |  | ADDRESS   |  |                          |  |                     |     |            |          |
|  |  |  |  | Mother  |  | Same as Above   |  |                          |  |                     |     |            |          |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):   |  |  |  |   |  |   |  |                          |  |                     |     |            |          |
| PART I. DEATH WAS CAUSED BY  |  |  |  |   |  |   |  |                          |  |                     |     |            |          |
| IMMEDIATE CAUSE (a) IMMATURITY   |  |  |  |   |  |   |  |                          |  |                     |     |            |          |
| 7651   |  |  |  |   |  |   |  |                          |  |                     |     |            |          |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |                          |  |                     |     |            |          |
| (b) _____  |  |  |  |   |  |   |  |                          |  |                     |     |            |          |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |                          |  |                     |     |            |          |
| (c) _____  |  |  |  |   |  |   |  |                          |  |                     |     |            |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |   |  |   |  |                          |  |                     |     |            |          |
|  |  |  |  |   |  |   |  |                          |  |                     |     |            |          |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                          |  |                     |     |            |          |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                          |  |                     |     |            |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                          |  |                     |     |            |          |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |   |  |                          |  |                     |     |            |          |
|  |  | P.M. 19  |  |   |  |   |  |                          |  |                     |     |            |          |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION   |  |   |  |                          |  |                     |     |            |          |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]   |  | STREET  |  | CITY OR TOWN  |  | COUNTY                   |  | STATE               |     |            |          |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/21, 19 79, to 5/21, 19 79, that (I) (we) last saw the deceased alive on 5/21/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |                          |  |                     |     |            |          |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  | 22c. DATE SIGNED  |  |                          |  |                     |     |            |          |
| [Signature]  |  | MD   |  |   |  | 5/21/79   |  |                          |  |                     |     |            |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |                          |  |                     |     |            |          |
| STEVEN WYNOR, MD   |  | PRINCE GEORGES GEN HOSP, CHEVERLY MD.  |  |   |  |   |  |                          |  |                     |     |            |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  | CITY OR TOWN             |  | COUNTY              |     | STATE      |          |
| cremation  |  | 7/18/79  |  | Prince George's Hospital  |  | Cheverly, P.G. Maryland   |  |                          |  |                     |     |            |          |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                          |  |                     |     |            |          |
| NAME   |  | ADDRESS  |  |   |  |   |  |                          |  |                     |     |            |          |
| Raleigh Cline, Cheverly, Maryland  |  | JUL 23 1979  |  | [Signature]   |  |   |  |                          |  |                     |     |            |          |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 374-3351.

DHMH - 16 50M 7/77  
(VR A 15 (4))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO.   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>James V. Little</b>   |  |  |  |   | 2a. DATE OF DEATH<br><b>June 7, 1979</b>   |  |  | 2b. HOUR<br><b>9:25A<sub>M</sub></b>                             |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 6, 1922</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Pr. Geo. Co.</b> MD.                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lanham</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pr. Geo. Doctor's Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Switchman</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>C&amp;P Phone Co.</b>    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>P.G.</b>   |  | 13c. CITY OR TOWN<br><b>Hyattsville</b>   |  | 13e. STREET ADDRESS<br><b>5209 56th. Ave.</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Howard I Little</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillie V. Compher</b>                    |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W.II</b>   |  | 17. INFORMANT<br><b>Sue A. Little</b>   |  | ADDRESS<br><b>Address Same as No # 13e.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>pneumonia</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>multistatic lung cancer</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (this hospital) attended this deceased from <b>7/9/79</b> to <b>6/7/79</b> , that (we) lost <b>6</b> saw the deceased die on <b>6/7/79</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated.  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE OF PHYSICIAN<br><b>Lewis H. Dennis</b>  |  | 22c. DATE SIGNED<br><b>June 7, 1979</b>  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Lewis H. Dennis, M.D.</b>   |  |  |  |  |  |
| 22e. ADDRESS<br><b>831 Univ. Blvd. E. Silver Spring, Md.</b>   |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>6-9-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood P.G. Md.</b>              |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>  |  |  |  |   | 25a. DATE AND BY REGISTERED<br><b>JUN 11 1979</b>  |  |  |  |  |

BP

200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |   | 7 9 1 5 5 5 3  |  |
|--|--|--|--|---|--|--|--|--|---|--|--|
| FOR<br>1 - STATE<br>REGISTRAR  |  |  | REG. NO.   |   |  |  |  |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FLOYD Franklin Lumpkins, Sr.  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 22, 1979                                 |  |  | 2b. HOUR<br>10:25A <sub>M</sub>   |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>March 23, 1909 <sup>R</sup>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS<br>HOURS MIN                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>W. Va.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George's MD.                          |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Lanham  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Doctors' Hospital of Pr. Geo. Co. |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Rail road        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Wash. Term. Co.   |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  | 13a. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13b. STREET ADDRESS<br>9617 Underwood St.  |   |  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>P.G.  |  | 13c. CITY OR TOWN<br>Seabrook   |  |  |  |  |   |  |  |
| 14. FATHER'S NAME<br>George W. Lumpkins  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>Anna Mae Pruitt   |  |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>--  |  | 17. INFORMANT<br>Sara M. Lumpkin  |  | ADDRESS<br>Same as #13   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Terminal Metastatic Cancer</u><br>1889<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>From urinary Bladder</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>From urinary Bladder</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 months |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>HYPERTENSIVE HT. HEART DISEASE, CHD, BRONCHITIS</u>  |  |  |  |   |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1977</u> , 19____, to <u>2-22-79</u> , 19____, that (I) (we) last saw the deceased alive on <u>2-22-79</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Andres C. Lara</u>  |  |  |  |   |  | DEGREE<br><u>MD</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><u>6-23-79</u>                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Andres Lara, M.D.   |  |  |  |   |  | 22e. ADDRESS<br>9326 Lanham-Severn Rd., Lanham, Md. 20801                            |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  |  | 23b. DATE<br>6-23-79   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Funeral Service                   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Alexandria County Alexandria, Va. |  |  |
| 24. FUNERAL DIRECTOR<br>F. Masch's Sons, P.A. Hyattsville, Md.   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 26 1979   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Jeffrey McCready</u>                           |  |  |

U C C C I F A

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

79

REG. NO.

15554

1. FOR  
STATE  
REGISTRAR

|  |   |  |        |                                     |  |   |                                   |      |          |
|--|---|--|--------|-------------------------------------|--|---|-----------------------------------|------|----------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | FIRST  | MIDDLE | LAST                                | 2a. DATE OF DEATH  | MONTH   | DAY                               | YEAR | 2b. HOUR |
| Mary Ann Malloy  |   |  |        |                                     | 06   | 08  | 79                                |      | 10:05A.  |
| 3 SEX  | 4 RACE  | 5 DATE OF BIRTH  |        | 6 AGE (IN YEARS LAST BIRTHDAY)      | IF UNDER 1 YEAR  |   | IF UNDER 24 HRS.                  |      |          |
| Female   | Caucasian   | 12 MONTH 22 DAY 07 YEAR  |        | 71                                  | MONTHS DAYS  |   | HOURS MIN.                        |      |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        | 9 BALTIMORE CITY OR COUNTY OF DEATH |  |   |                                   |      |          |
| Pennsylvania   | U.S.A.  |  |        | Prince George MD.                   |  |   |                                   |      |          |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |        |                                     | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY |      |          |
| Clinton  | Southern Maryland Hospital Center   |  |        |                                     | Sales Clerk  |   | Dept. Store                       |      |          |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)          |   |  |        |                                     | 13d. INSIDE CITY LIMITS?   |   |                                   |      |          |
| 13a. STATE   |   | 13b. COUNTY  |        | 13c. CITY OR TOWN                   |  | 13e. STREET ADDRESS   |                                   |      |          |
| Md.  |   | Pr. George   |        | Brandywine                          |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Rt. 2 Box 275 |                                   |      |          |
| 14. FATHER'S NAME  |   |  |        |                                     | 15. MOTHER'S MAIDEN NAME   |   |                                   |      |          |
| FIRST MIDDLE LAST<br>Andrew Yourkovick   |   |  |        |                                     | FIRST MIDDLE LAST  |   |                                   |      |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) |   |  |        |                                     | 16b. SOCIAL SECURITY NO.   |   |                                   |      |          |
| No   |   |  |        |                                     | 577-14-9386  |   |                                   |      |          |
| 17. INFORMANT  |   |  |        |                                     | ADDRESS  |   |                                   |      |          |
| Frank Malloy   |   |  |        |                                     | Same as 13 a-e.  |   |                                   |      |          |

## MEDICAL CERTIFICATION

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u><br>496-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Chronic obstructive Pulmonary Dis</u><br>(c) <u></u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 days<br>years |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hiatal hernia, Cholelithiasis

|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-8</u> 19 <u>79</u> to <u>6-8</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6-8</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><u>Daniel M. Howell</u>   |  | 22c. DATE SIGNED<br><u>6-8-79</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Daniel M. Howell   |  | 22e. ADDRESS<br>4400 Stamp Rd. Marlow Heights, Md.                                   |  |

|   |                           |   |  |
|---|---------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                  | 23b. DATE<br>Jun 11, 1979 | 23c. NAME OF CEMETERY OR CREMATORY<br>Resurrection Cem. | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Clinton Pr. George Md. |
| 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE<br>JUN 14 1979 |                           |   |  |

Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd. Clinton, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 1 5 5 5 5  |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR AM  |  |
| CHARMISSA MALONE  |  | D.   |  | MALONE   |  | JUNE   |  | 16 1979 7:47 AM   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | # UNDER 1 YEAR # UNDER 24 HRS.  |  |
| FEMALE  |  | NEGROID  |  | DEC 11 1978  |  | 6MTHS YRS. 6 5   |  | HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |
| MARYLAND  |  | USA  |  |  |  | PRINCE GEORGES COUNTY MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  |   |  |
| ANDREWS AFB   |  | MALCOLM GROW USAF MEDICAL CENTER   |  |  |  |  |  |   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |   |  |
| NA  |  | NA   |  |  |  |  |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS   |  |
| MARYLAND  |  | PRINCE GEO   |  | ANDREWS AFB  |  |  |  | 46 OAK ST   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |   |  |
| DATIS NMI MALONE  |  | EARLINE NMI TAYLOR   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS  |  |   |  |
| NO  |  | None   |  | NA   |  | SAME #15 SAME #13  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>7483<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>Bronchopulmonary Dysplasia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Premature birth 26 weeks gestation</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 13, 1979</u> , to <u>June 16, 1979</u> , that (I) (we) last saw the deceased alive on <u>June 16, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED   |  |   |  |
| <u>William A. Pollan D.O.</u>   |  |  |  |  |  | <u>16 June 79</u>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |  |  |   |  |
| WILLIAM A. POLLAN, CAPT, USAF, MD   |  | MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB DC 20331  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| Burial  |  | 6/20/79  |  | Vacaville - Elmira   |  | Vacaville Solano Cal.  |  |   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. RECEIVED BY   |  |  |  |   |  |
| Lee Funeral Home Inc.   |  | JUN 22 1979  |  | <u>William A. Pollan</u>   |  |  |  |   |  |
| 6633 Old Alexander Ferry Rd. Clinton, Md.   |  |  |  |  |  |  |  |   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                      |  |  |  |  |  |   |   |                      | 15556<br>REG. NO.   |  |
|---|----------------------|--|--|--|--|--|---|---|----------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>William M. MANN</b>   |                      |  |  |  |  |  |   |   |                      | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <b>6-15-79</b> |  |
| 3. SEX <b>Female</b>  | 4. RACE <b>White</b> | 5. DATE OF BIRTH <b>11-16-12</b>   |  | 6. AGE (IN YEARS) <b>66</b> YRS.                                       | IF UNDER 1 YR. MONTHS _____ DAYS _____   | IF UNDER 24 HRS. HOURS _____ MIN _____   | 2c. DATE PRONOUNCED DEAD <b>6-15-79</b>                   |   | 2d. HOUR <b>1953</b> |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD. |   |                      |   |  |
| 10. CITY OR TOWN OF DEATH <b>Lanham</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Doctor's Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>               |   | 12b. KIND OF BUSINESS OR INDUSTRY   |                      |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                      |  |  |  |  |  |   |   |                      |   |  |
| 13a. STATE <b>Penna.</b>  |                      | 13b. COUNTY <b>Franklin</b>  |  | 13c. CITY OR TOWN <b>Waynesboro</b>                                    |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS <b>Apt. #53 Mount Vernon Terrace</b>                      |                      |   |  |
| 14. FATHER'S NAME <b>Edward Wise</b>  |                      |  |  |  | 15. MOTHER'S MAIDEN NAME <b>Mamie Whittington</b>  |  |   |   |                      |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>  |                      | 16b. SOCIAL SECURITY NO. <b>-----</b>  |  | 17. INFORMANT <b>William Mann</b>                                      |  | ADDRESS <b>7303 Powhatan St. Lanham, Md.</b>   |   |   |                      |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: <b>Pulmonary thromboembolism</b><br>IMMEDIATE CAUSE (a) <b>4151</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.   |                      |  |  |  |  |  |   |   |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Arteriosclerosis cordis venous disease</b>  |                      |  |  |  |  |  |   |   |                      |   |  |
| 19a. DATE OF OPERATION  |                      |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |  |  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |                      |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                      |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR _____ P.M. _____ 19 _____ |  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                      |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                      |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)            |  |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |                      |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                      |  |  |  |  |  |   |   |                      |   |  |
| ACTUAL SIGNATURE <b>August P. Rodriguez MD</b>  |                      |  |  | TITLE (SPECIFY) <b>Deputy</b>  |  |  |   | MEDICAL EXAMINER DATE SIGNED <b>6-15-79</b>                                   |                      |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>August P. Rodriguez</b>  |                      |  |  | ADDRESS <b>7609 Rayburn Ct., Camp Springs, Md</b>                      |  |  |   |   |                      |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |                      |  |  | 23b. DATE <b>June 18, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Green Hill</b>   |   |   |                      | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waynesboro Franklin Penna.</b>   |  |
| 24. FUNERAL DIRECTOR <b>David P. Spive</b>  |                      |  |  | ADDRESS <b>50 S. Broad St., Waynesboro, Pa.</b>                        |  |  |   | 25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1979</b>                              |                      | 25b. REGISTRAR'S SIGNATURE <b>Richard McChesney</b>   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 22 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 15557  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Iretha E. MARSHALL</i>  |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <i>6-15 1979</i>        |  |
| 3. SEX <i>Female</i> 5. DATE OF BIRTH <i>2-21-13</i> 6. AGE (IN YEARS) <i>66</i> YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN   |  |  |  |  |  |  |  |  |  | 2b. HOUR <i>M</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>PISGAH, MD.</i>  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Bmore George</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH <i>ACCOKEEK, MD.</i>  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL FACILITY, GIVE STREET ADDRESS) <i>18001 LIVINGSTONE ROAD</i> |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK) <i>HOUSEWIFE</i>   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>   |  |
| 13a. STATE <i>MD.</i> 13b. COUNTY <i>PRINCE GEORGE</i> 13c. CITY OR TOWN <i>ACCOKEEK</i>  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME <i>JAMES PENNY</i>  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME <i>FRANCES L. SIMMONS</i>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. <i>215 36 3216</i>   |  |
| 17. INFORMANT ADDRESS <i>IRETHA F. ERWIN (SAME AS DECEDENT)</i>   |  |  |  |  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral aneurysm cardiac vascular distast</i><br><i>4292</i><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                                       |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <i>August P. Rodriguez</i> M.D. TITLE (SPECIFY) <i>Regulatory</i> MEDICAL EXAMINER   |  |  |  |  |  |  |  |  |  | DATE SIGNED <i>6-15-79</i>  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <i>August P. Rodriguez</i> ADDRESS <i>5009 Rayburn Ct. Camp Springs</i>   |  |  |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i>   |  |  |  |  |  |  |  |  |  | 23b. DATE <i>6/21/79</i>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <i>METROPOLITAN CHURCH</i>   |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN <i>POMONKEY, MARYLAND</i> COUNTY <i>202.61</i> STATE <i>MD</i>   |  |
| 24. FUNERAL DIRECTOR <i>ROBERT G. MASON, INC.</i> ADDRESS <i>WASHINGTON, D.C.</i>   |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <i>JUN 25 1979</i> 25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>   |  |

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 7 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>John D. Mason</b>  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 25, 1979</b>   |  | 2b. HOUR<br><b>2:01 P.M.</b>  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Sept 27, 1929</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>49 years</b>   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington D C</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's MD.</b>   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Prince George's Gen'l Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Lithographic Pressman</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U S Gov't-</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |  |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Pr. Geo's</b>   |  | 13c. CITY OR TOWN<br><b>Lanham</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>9891 Good Luck Rd Apt #4</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Raymond Mason</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lucy Gardner</b>   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>Yes 1948 to 1951</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>579 34 3046</b>  |  | 17. INFORMANT ADDRESS<br><b>Dolores Richard Alexandria Va</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>hypoglycemia or ketosis?</b><br><b>3500</b> DUE TO, OR AS A CONSEQUENCE OF:<br>(b)<br>(c) <b>Diabetes mellitus, tuberculosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3</b> 19 <b>73</b> , to <b>June 16</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>16</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)                      |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Dr. James Harding, M. D.</b> DEGREE   |  |   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6-25-79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. James Harding, M. D.</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>6201 Landover Road Cheverly, Md.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>June 28, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resurrection Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Clinton Pro Georges Md.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>Francis Gasch's Sons, PA Hyattsville, Md.</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 28 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |





*Diagnosis: ...*  
*... ..*

20% COTTON

*...*  
*...*  
*...*

*...*  
*...*  
*...*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |   |   |  |  |   |   |
|---|---|---|--|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Johnie Massey</i>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>6 15 79</i>                              |  | 2b. HOUR<br><i>9<sup>30</sup> A.M.</i>  |   |
| 3. SEX<br><i>Male</i>   | 4. RACE<br><i>Black</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>11/27/06</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>72</i> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><i>9 30</i> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Waxhaw, N.C.</i>                  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Prince Georges</i> MD.                              |   |   |
| 10. CITY OR TOWN OF DEATH<br><i>Tokoma Park</i>                                   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Washington Adventist Hospital</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. STATE<br><i>Maryland</i>   |   |   | 13b. COUNTY<br><i>Prince Georg.</i>  | 13c. CITY OR TOWN<br><i>Tokoma Pk.</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Saul Massey</i>                      |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Minnie Laury</i>               |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>no</i> |   | 16b. SOCIAL SECURITY NO.<br><i>578-28-3331</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>116 Lee Ave. #208</i><br><i>Florence Massey Tokoma Park, MD</i> |   |   |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <i>PULMONARY METASTASIS</i><br><i>1869</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>CARCINOMA OF TESTICLE</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><i>2 weeks</i><br><i>2 weeks</i> |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|   |  |  |   |
|---|--|--|---|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |

22a. I certify that (I) (this hospital) attended the deceased from *6/13* 19 *79*, to *6/15* 19 *79*, that (I) (we) last saw the deceased alive on *6/14* 19 *79*, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

|   |   |                                    |
|---|---|------------------------------------|
| 22b. SIGNATURE<br><i>Kirkland C. Brace</i>                        | DEGREE<br><i>M.D.</i>                                   | 22c. DATE SIGNED<br><i>6/15/79</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>KIRKLAND C. BRACE</i> | 22e. ADDRESS<br><i>7600 CARROLL AVE TAKOMA PARK, MD</i> |                                    |

|   |                             |   |   |
|---|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i> | 23b. DATE<br><i>6/19/79</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Harmony Memorial Pk.</i> | 23d. LOCATION/<br>CITY OR TOWN COUNTY STATE<br><i>Landover, P.G., Md.</i> |
|---|-----------------------------|---|---|

|   |   |   |
|---|---|---|
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>VANN E Williams 4804 Gt. Ave N.W. Wash. D.C.</i> | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 25 1979</i> | 25b. REGISTRAR'S SIGNATURE<br><i>Richard M. Brady</i> |
|---|---|---|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 1/75  
(VR A15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15560

|   |  |  |   |  |  |  |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  | 2a. DATE OF DEATH   |  |  | MONTH DAY YEAR   |  |  | 2b. HOUR   |  |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br><b>ARTHUR LEON MAYHEW</b>   |  |  | 2a. DATE OF DEATH<br><b>6-2-79</b>  |  |  | <b>12:16 AM</b>  |  |  |  |  |  |
| 3 SEX<br><b>MALE</b>  |  |  | 4 RACE<br><b>CAUC</b>   |  |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 12 05</b>  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>73</b> YRS  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>PRINCE GEORGE'S MD.</b>  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>CLINTON, MD</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTHERN MD HOSPITAL CENTER</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF OCCUPATION OR WORKING LIFE)<br><b>radiographer</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>NATL GEOGRAPHIC</b>  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>MD</b>  |  |  | 13b. COUNTY<br><b>P.G.</b>  |  |  | 13c. CITY OR TOWN<br><b>CAMP SPRINGS</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>EDWARD MAYHEW</b>  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>IDA ALLEN</b>   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO<br><b>579-48-8194</b>  |  |  |
| 17 INFORMANT WIFE   |  |  | ADDRESS<br><b>same as 13a</b>   |  |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL INSUFFICIENCY (COMA)</b><br>3320<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>PARKINSON'S DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>DEGENERATIVE PROCESS</b> |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>FEW DAYS</b><br><b>YRS</b><br><b>7</b>                                  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:<br><b>ABDOMINAL AORTIC ANEURYSM</b>  |  |  |   |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>9 9</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ABD. AORTIC ANEURYSM</b>   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAY, 10, 1979</b> to <b>JUNE 1, 1979</b> , that (I) (we) lost<br>saw the deceased alive on <b>JUN 1, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Michael G. Seremetis</b>   |  |  | DEGREE<br><b>M.D.</b>   |  |  | 22c. DATE SIGNED<br><b>JUN 5 1979</b>  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>M.G. SEREMETIS, MD</b>  |  |  | 22e. ADDRESS<br><b>3301 NEW MEX. AVE NW-WASH, DC</b>  |  |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>JUNE 5, 1979</b>   |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SUITLAND P.G. MD</b>   |  |  | 24 FUNERAL DIRECTOR<br>NAME<br><b>Geo P KALAS</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 5 1979</b>   |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Ray M. Brady</b>   |  |  | 25c. ADDRESS<br><b>6160 OXON HILL Rd OXON HILL MD.</b>  |  |  |  |  |  |  |  |  |

1904 BP



MEMORANDUM FOR THE RECORD  
SUBJECT: [Illegible]  
DATE: [Illegible]  
BY: [Illegible]

1. [Illegible]  
2. [Illegible]  
3. [Illegible]  
4. [Illegible]  
5. [Illegible]  
6. [Illegible]  
7. [Illegible]  
8. [Illegible]  
9. [Illegible]  
10. [Illegible]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |   |   |   |                                |   |   |  |   | 15561<br>REG. NO.                            |  |
|---|-------------------------|---|---|---|--------------------------------|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Lawrence M. McCall</i>   |                         |   |   |   |                                |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>6-8-79</i> |  | 2b. HOUR<br>M <i>11</i> A <i>09</i>                 |  |  |
| 3. SEX<br><i>Male</i>   | 4. RACE<br><i>White</i> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>2-18-23</i> | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <i>56</i> RS.  | IF UNDER 1 YR.<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN. | 7c. DATE PRONOUNCED<br><i>DEAD</i> <i>6-8-79</i>                                |   | 7d. HOUR<br>M <i>11</i> A <i>09</i>  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Penn.</i>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>     |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore</i> MD.                    |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Cherry (DOD)</i>  |                         |   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Prince Georges General Hosp.</i> |   |                                | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Plumber</i> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Retired</i> |  |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE <i>Maryland</i> 13c. COUNTY <i>Prince Georges</i> 13d. CITY OR TOWN <i>Oxon Hill</i>  |                         |   |   |   |                                |   | 13e. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  | 13f. STREET ADDRESS<br><i>8370 Indian Head # B1</i> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Lyle McCall</i>  |                         |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Unknown</i>   |                                |   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><i>Yes</i>   |                         | (IF YES, GIVE WAR OR DATES)<br><i>WW11</i>        |   | 16b. SOCIAL SECURITY NO.<br><i>208-22-8332</i>  |                                | 17. INFORMANT <i>WIFE</i> ADDRESS<br><i>Shirley L. McCall As in Item 13a</i>    |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><i>4392</i> IMMEDIATE CAUSE (a) <i>Coronary sclerosis and atherosclerosis of the heart</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |                         |   |   |   |                                |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><i>Chronic Obstructive pulmonary Disease</i>   |                         |   |   |   |                                |   |   |  |   |  |  |
| 19a. DATE OF OPERATION  |                         |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                                |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>           |   |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>   |                                | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         |   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                                | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |   |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |   |   |                                |   |   |  |   |  |  |
| ACTUAL SIGNATURE <i>August P. Rodriguez</i>   |                         |   |   | TIME (SPECIFY)<br>M.D. <i>July</i>  |                                | MEDICAL EXAMINER  |   | DATE SIGNED <i>6-8-79</i>  |   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <i>August P. Rodriguez</i>  |                         |   |   | ADDRESS <i>5069 Rayburn Court, Camp Springs, Md 20746</i>   |                                |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |                         | 23b. DATE<br><i>6-11-1979</i>                     |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Arlington, National</i>  |                                |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Fort Meyer Arlington Virginia</i> |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>George P. Kalas</i> ADDRESS <i>6160 Oxon Hill Road Oxon Hill Maryland</i>   |                         |   |   |   |                                | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 11 1979</i>                             |   | 25b. REGISTRAR'S SIGNATURE<br><i>Anthony McKeown</i>                               |   |  |  |

10000





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |   |   |   |   |  |  |   |  | 15562<br>REG. NO.  |  |   |  |
|---|-------------------------|---|---|---|---|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Willie Mae McClellan (Scriber)</b>   |                         |   |   |   |   |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>6-2 1979</b> |  |   |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>6-3-52</b>                | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/><br><b>26 YRS.</b> | IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN <input type="checkbox"/> | 7c. DATE PRONOUNCED DEAD<br>MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/><br><b>6-2 1979</b> |  | 7b. HOUR<br>M <input type="checkbox"/> A <input checked="" type="checkbox"/>        |  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. CAROLINA</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges</b> MD.  |  |   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>CHEVERLY</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PRINCE GEORGE'S HOSPITAL</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>STUDENT</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SCHOOL</b>                                  |  |  |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>D.C.</b> 13b. COUNTY <b>NONE</b> 13c. CITY OR TOWN <b>Washington D.C.</b>   |                         |   |   |   |   |  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>1421 12th Street NW</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>WILL</b> MIDDLE <b>MC</b> LAST <b>CLELLAN</b>   |                         |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>DORIS</b> MIDDLE <b>JONES</b> LAST <b>JONES</b>  |   |  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>579-74-3264</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>MARY N. GIBSON 4420 G ST. S.E. WASH.D.C.</b>   |   |  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Accidental drowning</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |                         |   |   |   |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |   |   |   |   |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |                         |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>3:30 P.M. 5-27-79</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Drowned while rescuing her child</b>                 |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |                         |   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Residential Apt</b>   |   | 21f. LOCATION<br>STREET <b>7109 Piny Trail Court</b> CITY/TOWN <b>Adelphi</b> COUNTY <b>Prince Georges</b> STATE <b>Md.</b>              |  |   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |                         |   |   |   |   |  |  |   |  | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion                 |  |   |  |
| ACTUAL SIGNATURE<br><b>August P. Rodriguez</b>  |                         |   |   | TITLE (SPECIFY)<br><b>Physician</b>   |   |  |  | MEDICAL EXAMINER<br><b>August P. Rodriguez</b>                                      |  | DATE SIGNED<br><b>6-2-79</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>August P. Rodriguez</b>   |                         |   |   | ADDRESS<br><b>8009 Rayburn Pl. Camp Springs Md.</b>   |   |  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>6-12-1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HARMONY MEM. PARK</b>  |   |  |  | 23d. LOCATION<br>CITY OR TOWN <b>LANDOVER</b> COUNTY <b>P.G.C.</b> STATE <b>Md.</b> |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>W. W. CHAMBERS CO. 517 11th ST. S.E. WASH.D.C.</b>   |                         |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 15 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Horton McCready</b>                                |  |  |  |   |  |

(M)

(10)

U.S. MARINE CORPS

U.S.A.

X

FRANCE GEORGE HOSPITAL

STUDENT

SENIOR

HOME

NO.

NO. 1000

NO. 1000

NO. 1000

27-7A-386

FRY ST. GINSON

4400 E. ST. S.E. WASH.D.C.

*Handwritten signature*

*Handwritten text, possibly a letter or note*

*Handwritten text, possibly a letter or note*

6-12-1979

W. PARK

W. PARK

W. PARK

U.S. MARINE CORPS 217 HIGH ST. S.E. WASH.D.C. 20003

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |   |   |   |   |  |  |   | 15563<br>REG. NO.  |                     |          |  |
|--|--|--|--|--|---|---|---|---|--|--|---|--|---------------------|----------|--|
| 1- STATE REGISTRAR   |  |  |  |  |   |   |   |   |  |  |   |  |                     |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br>Helen   |  |   | MIDDLE<br>V.  |   |   | LAST<br>McDonald   |  |   | 2a. DATE OF DEATH  |                     | 2b. HOUR |  |
| 3. SEX<br>Female   |  |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>6-17-13 |   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br>66 YRS. |   | 7. IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>6-22-79 |  | 2d. HOUR<br>1:30 PM |          |  |
| 7a. BIRTHPLACE (STATE OR COUNTY)<br>Maryland   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George MD.  |  |   |  |                     |          |  |
| 10. CITY OR TOWN OF DEATH<br>Cheverly  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Prince George Hospital |  |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cafeteria Work |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Public School    |  |                     |          |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |   |   |   |   |  |  |   |  |                     |          |  |
| 13a. STATE<br>Maryland   |  |  | 13b. CITY OR TOWN<br>Prince George   |  |   | 13c. CITY OR TOWN<br>District Hgts.   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  | 13e. STREET ADDRESS<br>5970 Walker Mill Rd.           |  |                     |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Walter John Ogden  |  |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice M. Day   |   |   |  |  |   |  |                     |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |  | (IF YES, GIVE WAR OR DATES)  |  |   | 16b. SOCIAL SECURITY NO.<br>214-03-6589a  |   |   | 17. INFORMANT<br>Barbara Taylor  |  |   | ADDRESS<br>3208 Newkirk Ave.<br>Foresville, Md.                          |                     |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia due to aspiration</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. |  |  |  |  |   |   |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |                     |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |   |   |   |   |  |  |   |  |                     |          |  |
| 19a. DATE OF OPERATION   |  |  |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                     |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>11:30 P.M. 6-22-79   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br>Choked while eating                     |  |   |  |                     |          |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |  |  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Home   |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>6970 Walker Mills Rd. Prince George, Dist. Hgts. Prince George, Md. |  |   |  |                     |          |  |
| 22a. I certify that I took charge of the remains described above, held in death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |  |  |  |   |   |   |   |  |  |   |  |                     |          |  |
| ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u>   |  |  |  |  |   | TITLE (SPECIFY)<br>Deputy MEDICAL EXAMINER  |   |   |  |  |   | DATE SIGNED <u>6-22-79</u>   |                     |          |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Augusto P. Rodriguez, M.D.  |  |  |  |  |   | 5009 Rayburn Ct., Camp Springs, Md. 20031 ADDRESS   |   |   |  |  |   |  |                     |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |  | 23b. DATE<br>6-26-1979   |  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Bells Meth. Church Cem.   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Camp Springs Prince Geo. Maryland  |  |   |  |                     |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Funeral George P. Kates<br>Home  |  |  |  |  |   | Oxon Hill, Md.<br>6160 Oxon Hil Rd.   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUN 26 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Barbara Taylor</u>   |  |                     |          |  |

00001 11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |                                    |  |                               |  |   |  |  |
|--|--|--|--|--|------------------------------------|--|-------------------------------|--|---|--|--|
| 1. FOR STATE REGISTRAR   |  | 7. 15564   |  | REG. NO.   |                                    |  |                               |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST                                |  |                                    | 2a. DATE OF DEATH  |                               | MONTH DAY YEAR   |   | 2b. HOUR MIN                                 |  |
| Lucy A. Mc. Donnell  |  |  |  |  |                                    | 6 14 79  |                               |  |   | 12 P.M.                                      |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)  |                               | IF UNDER 1 YEAR  |   | IF UNDER 24 HRS                              |  |
| Female   |  | White  |  | August 5, 1883   |                                    | 95 YRS   |                               | MONTHS DAYS  |   | HOURS MIN                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH   |                               |  |   |  |  |
| South Dakota   |  | U.S.A.   |  |  |                                    | Prince George's County MD.   |                               |  |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |                                    | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                               | 12b. KIND OF BUSINESS OR INDUSTRY                              |   |  |  |
| Greenbelt  |  | Greenbelt Conv. Center   |  |  |                                    | Housewife  |                               | Home   |   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13a. COUNTY                                      |  |                                    | 13b. CITY OR TOWN  |                               |  | 13c. INSIDE CITY LIMITS?  |  |  |
| 13a. STATE   |  |  | 13b. COUNTY                                      |  |                                    | 13c. CITY OR TOWN  |                               |  | 13d. STREET ADDRESS   |  |  |
| Virginia   |  |  | Page   |  |                                    | Luray  |                               |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME                         |  |                                    |  |                               |  |   |  |  |
| Unknown  |  |  | Unknown  |  |                                    |  |                               |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.                         |  |                                    | 17. INFORMANT ADDRESS  |                               |  |   |  |  |
| No   |  |  | None   |  |                                    | 503-24-7426 Henry C. Mc Donnell Same as # 13   |                               |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.  |  |  |  |  |                                    |  |                               |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u>  |  |  |  |  |                                    |  |                               |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anterior Branch Heart Disease</u>  |  |  |  |  |                                    |  |                               |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>4140</u>   |  |  |  |  |                                    |  |                               |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |                                    |  |                               |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |                                    | 20a. AUTOPSY?  |                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |   |  |  |
|  |  |  |  |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               | YES <input type="checkbox"/> NO <input type="checkbox"/>       |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY                              |  |                                    | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |                               |  |   |  |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR                         |  |                                    |  |                               |  |   |  |  |
|  |  |  | P.M. 19  |  |                                    |  |                               |  |   |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY                             |  |                                    | 21f. LOCATION  |                               |  |   |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |                                    | STREET   |                               |  | CITY OR TOWN COUNTY STATE   |  |  |
| 22. I certify that (a) (this hospital) attended the deceased from <u>2/2</u> 19 <u>76</u> , to <u>6/14</u> 19 <u>79</u> , that (b) (we) lost saw the deceased alive on <u>6/14</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. |  |  |  |  |                                    |  |                               |  |   |  |  |
| 22a. SIGNATURE   |  |  | DEGREE   |  |                                    | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |                               |  | 22c. DATE SIGNED  |  |  |
| David Schachter  |  |  | D.O.   |  |                                    |  |                               |  | 6/14/79   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS                                     |  |                                    |  |                               |  |   |  |  |
| DAVID Schachter  |  |  | 115 Contingency Greenbelt, Md 20770              |  |                                    |  |                               |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION                 |  | COUNTY STATE  |  |  |
| Burial   |  |  | 6/15/79  |  | Gate of Heaven Cem.                |  | Silver Spring, Mont. Co., Md. |  |   |  |  |
| 24. FUNERAL DIRECTOR   |  |  | 25a. DATE REC'D. BY REGISTRAR                    |  |                                    | 25b. REGISTRAR'S SIGNATURE   |                               |  |   |  |  |
| NAME ADDRESS   |  |  | JUN 19 1979                                      |  |                                    | History McBrady  |                               |  |   |  |  |
| Chambers Funeral Home  |  |  | Riversdale, Maryland                             |  |                                    |  |                               |  |   |  |  |

BP

DHMM-16 20M  
(VRA 15, 4) 7/78

10001-11



RELEASED BY DR ROBRQUEZ, M.D. - 4/17/79

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15565

|  |         |                  |   |  |  |  |  |  |
|--|---------|------------------|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |                  | 2a. DATE OF DEATH   |  |  | 2b. HOUR   |  |  |
| GRACE EUDORA McELHINEY   |         |                  | June 17, 1979   |  |  | 11:10A   |  |  |
| 3 SEX  | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY)   |  |  | 7. UNDER 1 YEAR  |  |  |
| Female   | White   | March 22, 1890   | 89 YRS.   |  |  | 8. UNDER 24 HRS  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         |                  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |
| Pennsylvania   |         |                  | U. S. A.  |  |  | Prince Georges MD.   |  |  |
| 10. CITY OR TOWN OF DEATH  |         |                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  |  |
| Lanham   |         |                  | Doctors' Hospital of P.G. County  |  |  | Housewife  |  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |         |                  | 13a. STREET ADDRESS   |  |  | 13b. INSIDE CITY LIMITS?   |  |  |
| Own Home   |         |                  | 12111 Lerner Place  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |  |
| 14. FATHER'S NAME  |         |                  | 15. MOTHER'S MAIDEN NAME  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                                   |  |  |
| Charles Wesley Milliron  |         |                  | Minnie (Davis, n)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  |
| 16a. YES, NO OR UNKNOWN  |         |                  | 16b. YES, NO OR UNKNOWN   |  |  | 17. INFORMANT  |  |  |
| No   |         |                  | No  |  |  | Mrs. Donna Lee-Bowie, Md. 20715  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br>436-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |         |                  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |                  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|  |         |                  |   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |         |                  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |                  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 17, 1979, to June 17, 1979, that (I) (we) last saw the deceased alive on June 17, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)                        |         |                  | 22b. SIGNATURE<br>Rafael C. Lee, M.D.   |  |  | 22c. DATE SIGNED<br>6/17/79  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |         |                  | 22e. ADDRESS  |  |  | 22f. DATE REC'D. BY REGISTRAR  |  |  |
| RAFAEL C. LEE, M.D.  |         |                  | Clinton Md 20735  |  |  | JUN 21 1979  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |         |                  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |
| Burial   |         |                  | 6/21/79   |  |  | Glade Run Presb. Cem. Dayton Penna.  |  |  |
| 24. FUNERAL DIRECTOR   |         |                  | 25a. DATE REC'D. BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |
| Richard A. Coleman-Upper Marlboro, Maryland 20870  |         |                  | JUN 21 1979   |  |  | [Signature]  |  |  |





RECEIVED  
JAN 21 1950  
U.S. DEPT. OF JUSTICE

James Earl Ray  
January 17, 1950  
San Francisco, California  
Dear Sir:  
I am writing you in regard to the letter  
you received from the Federal Bureau of Investigation  
on January 11, 1950, regarding the matter of  
the "Black Book" of the United States.  
I am sorry that I cannot give you more information  
at this time, but I am sure that you will  
understand my position.

Very truly yours,  
James Earl Ray  
San Francisco, California  
Enclosed for you are two copies of the letter  
which I received from the Federal Bureau of Investigation  
on January 11, 1950, regarding the matter of  
the "Black Book" of the United States.  
I am sure that you will find this information  
of interest.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1- FOR STATE REGISTRAR   |  |  | 7 9 1 5 5 6 6   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH   |  |  |
| NEVA ANNA McGRAW   |  |  | JUNE 21, 1979   |  |  |
| 3. SEX<br>FEMALE   |  |  | 7b. HOUR<br>6:17A M   |  |  |
| 4. RACE<br>WHITE   |  |  | 5. DATE OF BIRTH<br>APRIL 6, 1929   |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>50 YRS.   |  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEBRASKA  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGES COUNTY MD.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>ANDREWS AFB   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>MALCOLM GROW USAF MEDICAL CENTER |  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. STATE<br>MARYLAND   |  |  | 13b. COUNTY<br>PG   |  |  |
| 13c. CITY OR TOWN<br>CLINTON   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 13e. STREET ADDRESS<br>11126 PISCATAWAY RD. 20735  |  |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>STEVE CROOKSHANK (D)   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>ORA EDWARDS  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  |  | 16b. SOCIAL SECURITY NO.<br>549-76-6104   |  |  |
| 17. INFORMANT<br>ADDRESS<br>KENT A. McGRAW (H) SAME AS ITEM #13e   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardioresp. arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>osteogenic sarcoma, metastatic</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>renal failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11 June</u> 19 <u>79</u> , to <u>21 June</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>21 June</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.                                |  |  |   |  |  |
| 22b. SIGNATURE<br><u>MD Daniels</u>  |  |  | 22c. DATE SIGNED<br>21 JUN 79   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL O. DANIELS, CAPT, USAF, MC  |  |  | 22e. ADDRESS<br>MALCOLM GROW USAF MEDICAL CENTER<br>ANDREWS AFB, MARYLAND 20331   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>6-25-79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington Nat.                                 |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arlington, Virginia  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Robt E Wilhelm<br>Funeral Home   |  | ADDRESS<br>4308 Suitland Rd., Suitland, Md.                            |   | 25a. DATE REG. BY REGISTRAR<br>JUN 26 1979   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Jeffrey McCready</u>  |  |  |   |  |  |



25 MAY 15



1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15567

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HELEN Ann McLAUGHLIN</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>6/18/79</b>                     |   |  | 2b. HOUR<br><b>5:26 P M</b>   |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>9 9 08</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>Conn.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>PRINCE GEORGE'S</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CLINTON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>50 MD HOSPITAL CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Charles</b>  |  | 13c. CITY OR TOWN<br><b>LA PLATA</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>RT 1 BOX 1060 B</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Dominic Falasca</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Claudia Cerillo</b>           |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>049-14-2820A</b>  |  | 17. INFORMANT<br>ADDRESS <b>Patricia Mc Laughlin same as #13</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Endometrium</b><br><b>1820</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastases to Brain</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastases to Lungs</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Yes</b><br><b>Yes</b> |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/30 19 79</b> to <b>6/18 19 79</b> , that (I) (we) last saw the deceased alive on <b>6/18 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>R. M. NOSTRAN</b>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6/19/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. M. NOSTRAN</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>4235 26th Ave NW NW 20034</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |  | 23b. DATE<br><b>6-21-79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Johns Cemetery</b>                |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Norwalk Fairfield Conn.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Huntt Funeral Home</b>   |  |  |  |   |  | ADDRESS<br><b>Waldorf, Maryland</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 22 1979</b>  |  |
|   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Deborah K. Christy</b>   |  |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP \_\_\_\_\_



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15568

|   |  |   |  |   |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
|---|--|---|--|---|--|---|--|-----------------------------------|--|--|--|--------------------------------------|--|------------------|--|-------------------|--|--------------------------|--|--------------------------|--|-----------|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE KNOWN OF DEATH   |  | 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH                  |  | 6. AGE (IN YEARS)                            |  | IF UNDER 1 YR.                       |  | IF UNDER 24 HRS. |  | 7b. DATE OF DEATH |  | 7c. DATE PRONOUNCED DEAD |  | 7d. HOUR                 |  |           |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST   |  | 2a. DATE KNOWN OF DEATH   |  | 3. SEX  |  | 4. RACE                           |  | 5. DATE OF BIRTH                             |  | 6. AGE (IN YEARS)                    |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.  |  | 7b. DATE OF DEATH        |  | 7c. DATE PRONOUNCED DEAD |  | 7d. HOUR  |  |
| LYON  |  | VIVIAN  |  | MCMURRAY  |  | Male  |  | Cau                               |  | Mar 12 17                                    |  | 62 YRS.                              |  |                  |  |                   |  | June 23 1979             |  | 9:25 p.m.                |  | 9:25 p.m. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED  |  | NEVER MARRIED   |  | WIDOWED                           |  | DIVORCED                                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |                  |  |                   |  |                          |  |                          |  |           |  |
| Washington DC   |  | USA   |  | X   |  |   |  |                                   |  |  |  | Prince Georges                       |  |                  |  |                   |  |                          |  |                          |  |           |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| Andrews AFB, MD   |  | Malcolm Grow USAF Med Cen   |  | Ticket Agent  |  | Railroad  |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?          |  | 13e. STREET ADDRESS                          |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| Maryland  |  | Prince Georges  |  | District Hghts  |  | YES X NO  |  | 6211 District Heights Parkway     |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  |   |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST   |  |   |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| Thomas  |  | L. McMurray   |  | Martha  |  | Ellen   |  | Dement                            |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | ADDRESS   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| NO  |  | 578-09-9744   |  | Robert L. McMurray  |  | Box 342   |  | Chesapeake Beach, MD              |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line) (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)         |  | 19. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |  | 20. AUTOPSY?  |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| 4292  |  | June 15/79  |  | Colonay by pass   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                       |  |   |  |   |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| (c)   |  |   |  |   |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |   |  |   |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
|   |  |   |  |   |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY?  |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| June 15/79  |  | Colonay by pass   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                 |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
|   |  | P.M. 19   |  |   |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK     |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION   |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
|   |  |   |  | STREET CITY OR TOWN COUNTY STATE  |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| 22a. I certify that I took charge of the remains described above, held on   |  | Autopsy <input type="checkbox"/>  |  | Inspection <input type="checkbox"/>   |  | Inquiry <input type="checkbox"/>                                    |  | and in my opinion                 |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| death resulted from:  |  | Natural causes <input checked="" type="checkbox"/>  |  | Accident <input type="checkbox"/>   |  | Suicide <input type="checkbox"/>                                    |  | Homicide <input type="checkbox"/> |  | Undetermined manner <input type="checkbox"/> |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)   |  | DATE SIGNED   |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| Augusto P. R. Vignone   |  | M.D. Deputy   |  | 6-24-79   |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS   |  |   |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| Augusto P. R. Vignone   |  | 5009 Rayburn Ct., Camp Spring   |  |   |  |   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| Burial  |  | 6-27-1979   |  | Resurrection Cemetery   |  | Clinton   |  | P.G. Maryland                     |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |
| James P. Belas  |  | 6100-0X on Hill Rd.   |  | JUN 27 1979   |  | Anthony McCreedy  |  |                                   |  |  |  |                                      |  |                  |  |                   |  |                          |  |                          |  |           |  |

1 2 0 0 0

WASHINGTON, D. C. 20540

OFFICE OF THE SECRETARY OF DEFENSE

ATTENTION: SECRETARY OF DEFENSE

WASHINGTON, D. C. 20540

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OFFICE OF THE SECRETARY OF DEFENSE

ATTENTION: SECRETARY OF DEFENSE



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                            |  |   |  |   |  |   |  |  |  | 15569<br>REG. NO.  |  |                              |  |
|--|--|----------------------------|--|---|--|---|--|---|--|--|--|--|--|------------------------------|--|
| 1. FOR STATE REGISTRAR   |  |                            |  |   |  |   |  |   |  |  |  |  |  |                              |  |
| 2. DECEASED NAME<br>(TYPE OR PRINT) <b>Kenneth Arthur McNEY Jr.</b>  |  |                            |  |   |  |   |  |   |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>6-2 1979</b>                     |  | 2b. HOUR<br><b>2:50 A.M.</b> |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>3-10-61</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>18</b>   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br><b>6-2 1979</b>                            |  | 7d. HOUR<br><b>2:50 A.M.</b>   |  |                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington DC</b>  |  |                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George</b>             |  | MD.                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Clinton</b>  |  |                            |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Southern Maryland Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                         |  |                              |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |                            |  |   |  |   |  |   |  |  |  |  |  |                              |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>P.G.</b> |  | 13c. CITY OR TOWN<br><b>Camp Springs</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>5131 Carton Ave.</b>  |  |  |  |  |  |                              |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Kenneth McNEY Sr.</b>   |  |                            |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Alice E. Windsor</b>                        |  |   |  |  |  |  |  |                              |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |  |                            |  | 16b. SOCIAL SECURITY NO.<br><b>577-94-8108</b>  |  |   |  | 17. INFORMANT<br><b>Kenneth A. McNey Sr. same as #13</b>  |  |  |  | ADDRESS  |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                            |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                            |  |   |  |   |  |   |  |  |  |  |  |                              |  |
| 19a. DATE OF OPERATION   |  |                            |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                            |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2:00 P.M. 6-2 1979</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Auto-auto collision</b>   |  |  |  |  |  |                              |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                            |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Street</b>  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>6900 Block, Alden Hampton Rd, Camp Springs Prince Georges Md.</b>                                   |  |  |  |  |  |                              |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |                            |  |   |  |   |  |   |  |  |  |  |  |                              |  |
| ACTUAL SIGNATURE<br><b>Augusto P. Rodriguez</b>  |  |                            |  | DATE (SPECIFY)<br><b>6-2-79</b>   |  |   |  | MEDICAL EXAMINER<br><b>Deputy</b>   |  |  |  | DATE SIGNED<br><b>6-2-79</b>   |  |                              |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Augusto P. Rodriguez</b>   |  |                            |  | ADDRESS<br><b>5009 Rayburn Ct. Camp Springs</b>   |  |   |  |   |  |  |  |  |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                            |  | 23b. DATE<br><b>6/5/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington National Cem</b>                            |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland P.G. Md.</b> |  |  |  |                              |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Lee Funeral Home Inc. 6633 Old Alexander Ferry Rd. Clinton, Md</b>  |  |                            |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 8 1979</b>  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b>   |  |  |  |  |  |                              |  |

BP

Figure 1

Clinton

Southern General Hospital

Abstract:

124

• •

2121 Carlton Ave.

Kennedy McNeely, Jr.

Alfred E. Folsom

277-94-8108 Kenneth A. Baker Sr., same as #11

52

1990-1991

1000

07/2/10

1. *Introduction*

The General Insurance Co.

100

1994

• 10771 •

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 13. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73  
(VR A15 ME (5))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15570

|   |  |  |   |   |                             |
|---|--|--|---|---|-----------------------------|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE KNOWN OF DEATH  |   | 2b. HOUR  |                             |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Mildred Soderberg MELIN</i>   |  | 2a. DATE KNOWN OF DEATH <i>6-15 1979</i>   |   | 2b. HOUR <i>8:45 P</i>  |                             |
| 3. SEX <i>Female</i>  | 4. RACE <i>White</i>   | 5. DATE OF BIRTH <i>11-27-13</i>   | 6. AGE (IN YEARS) <i>65</i> YRS.                      | IF UNDER 1 YR. MONTHS DAYS  | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Sweden</i>   | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i> |   |                             |
| 10. CITY OR TOWN OF DEATH <i>Temple Hills</i>   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3251 28th. Parway</i> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>National Science Foundation</i>   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |                             |
| 13a. STATE <i>Maryland</i>  |  | 13b. COUNTY <i>P. G.</i>   |   | 13c. CITY OR TOWN <i>Temple Hills</i>   |                             |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <i>Theodore Soderberg</i>   |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <i>Constance Anderson</i>   |   | 16. SOCIAL SECURITY NO. <i>089 07 6549</i>  |                             |
| 17. INFORMANT ADDRESS <i>Jermiah J. Dee 3126 28th Parkway</i>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Asphyxia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                             |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |   |   |                             |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                             |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 6-15 1979</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Hanged self</i>              |                             |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>  |   | 21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) <i>2231 28th Parkway, Hillcrest, HTS. Prince Georges, Md</i> |                             |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and my opinion |  |  |   |   |                             |
| ACTUAL SIGNATURE <i>August P. Rodenbach</i>   |  | TITLE (SPECIFY) <i>Deputy</i>  |   | DATE SIGNED <i>6-15-79</i>  |                             |
| EXAMINER'S NAME (TYPE OR PRINT) <i>August P. Rodenbach</i>  |  | ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md</i>  |   |   |                             |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>  |  | 23b. DATE <i>June 16, 1979</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>  |                             |
| 24. FUNERAL DIRECTOR NAME <i>Robert E. Wilhelm</i>  |  | ADDRESS <i>4308 Suitland Rd. Suitland Md.</i>  |   | 25a. DATE REC'D. BY REGISTRAR <i>JUN 18 1979</i>  |                             |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE <i>Litkey/Kaloudy</i>  |                             |

MEDICAL CERTIFICATION

19 1 2 3 4 5

James M. Smith  
1911

Temple Hill  
Maryland  
1911

James M. Smith  
1911

James M. Smith  
1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 7 9 1 5 5 7 1<br>REG. NO.  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR                                     |  |
| ROBERT K MILLER  |  |  |  |  |  |  |  | 06 26 79   |  | 8:50 A M                                     |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| Male   |  | White  |  | Oct 25 1923  |  | 55   |  |  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |  |  |  |
| Maryland   |  | USA  |  |  |  | PRINCE GEORGE'S COUNTY MD.   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| CHEVERLY   |  | PRINCE GEORGE'S GENERAL HOSPITAL   |  |  |  |  |  | Self-Emp. Contractor   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |  |  |  |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS  |  |  |  |
| Md.  |  | P.G.   |  | Upper Marlboro   |  |  |  | 11001 Winsford Avenue  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |  |  |  |  |
| Albert R. Miller   |  |  |  | Minnie I. Cline  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |  |  |  |  |
| Yes  |  |  |  | 217-16-2392  |  | Dorothy Miller, Wife, Same as Above  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral edema + compression</u>   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 430-<br>DUE TO, OR AS A CONSEQUENCE OF <u>subarachnoid hemorrhage</u>  |  |  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF <u>Cerebral aneurysm</u>  |  |  |  |  |  |  |  |  |  |  |  |
| (c)  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 25</u> 19 <u>75</u> to <u>6-26</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-26</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <u>James Hardin</u>   |  |  |  | DEGREE   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <u>6/26/79</u>              |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| Burial   |  | 6-29-79  |  | Rest Haven Cem.  |  | Hagerstown, Wash., Md.   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  | 24b. ADDRESS   |  |  |  | 25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| Robt E Wilhelm   |  |  |  | 4308 Suitland Rd., Suitland, Md  |  |  |  | JUL 2 1979 <u>Henry McCreedy</u>   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 79 15572  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth Kirby Millikin  |  |   |  | (June) 6 18 79 11 A.M.   |  |   |  |
| 3. SEX Female   |  | 4. RACE Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 3, 1891   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.  |  |
| 10. CITY OR TOWN OF DEATH Greenbelt   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Convalescent Center          |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY Home  |  |
| 13a. STATE Maryland   |  | 13b. COUNTY P.G.  |  | 13c. CITY OR TOWN College Park   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST William B. McLaughlin   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate Sturtevant  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO 060-01-0457   |  |
| 17. INFORMANT ADDRESS 7507 Creighton Dr. Sturtevant Millikin (Son) College Park, Md.  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) cerebral infarction |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days  |  |   |  |
| 4349  |  | DUE TO, OR AS A CONSEQUENCE OF (b)  |  | DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |  |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from OCT. 19 76, to June 18, 19 79, that (I) (we) lost saw the deceased alive on June 14, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE William B. Gunther   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED 6/18/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) William B. Gunther  |  | 22e. ADDRESS 4917 Edgewood Rd., College Park, Maryland  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE June 20, 1979   |  | 23c. NAME OF CEMETERY OR CREMATORY Arlington National  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia   |  |
| 24. FUNERAL DIRECTOR NAME Capitol Funeral Service   |  | ADDRESS Fairfax, Va.  |  | 25a. DATE REC'D. BY REGISTRAR JUN 22 1979  |  | 25b. REGISTRAR'S SIGNATURE Patrick McCreedy   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |  |   |  |  | 7 9 1 5 5 7 3 |  |
|--|--|--|---|--|--|--|---|--|--|---------------|--|
| 1. FOR STATE REGISTRAR   |  |  | 2a. DATE OF DEATH                                       |  |  |  | MONTH DAY YEAR  |  | 2b. HOUR   |               |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  | FIRST   |  | MIDDLE   |  | LAST  |  | 2b. HOUR   |               |  |
| NATHANIEL  |  |  | E.  |  | MILNER   |  | 06 27 79  |  | 12:15 PM   |               |  |
| 3. SEX   |  |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | 7. IF UNDER 1 YEAR   |               |  |
| MALE   |  |  | BLACK   |  | JUN. 17, 1908  |  | 71 YRS.   |  | MONTHS DAYS HOURS MIN.   |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?                            |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  | 10. PRINCE GEORGE'S COUNTY                                     |               |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13. MD.  |               |  |
| CHEVERLY   |  |  | PRINCE GEORGE'S GENERAL HOSPITAL                        |  | RETIRED  |  | GOVERNMENT  |  |  |               |  |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?                                       |               |  |
| MD.  |  |  | PRINCE GEORGE   |  | CHAPEL OAKS  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |  | 13e. STREET ADDRESS  |               |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME                                |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |               |  |
| NOAH D. MILNER   |  |  | LILLIAN G. EZELL  |  | YES  |  | 487 12 5784   |  | FLOSSIE E. MILNER (SAME AS DECEDENT)                           |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  | 18a. IMMEDIATE CAUSE (a)                                |  | 18b. DUE TO, OR AS A CONSEQUENCE OF  |  | 18c. DUE TO, OR AS A CONSEQUENCE OF   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                   |               |  |
| 1552   |  |  | Lower Gastrointestinal Bleeding                         |  | Hepatic Failure  |  | Carcinoma of the Liver  |  | hours  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                |  |  | 19a. DATE OF OPERATION                                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |               |  |
|  |  |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  |  | 21b. TIME OF INJURY                                     |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY   |               |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR                                |  |  |  | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | CITY OR TOWN COUNTY STATE                                      |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  |  | 6-27-1979   |  | to 6-27-1979   |  | that (I) (we) last saw the deceased alive on                                      |  | 6-27-1979  |               |  |
| above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |  |   |  |  |               |  |
| 22b. SIGNATURE   |  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED  |  | 6-27-79  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY                             |               |  |
| MAHMOUDULLAH BAIG  |  |  | 3454 FORT MEADE RD. LAUREL, MD                          |  | BURIAL   |  | JUL 2, 1979   |  | Arlington Cem.   |               |  |
| 24. FUNERAL DIRECTOR'S NAME  |  |  | 24b. ADDRESS  |  | 24c. CITY OR TOWN  |  | 24d. COUNTY   |  | 24e. STATE   |               |  |
| ROBERT G. HENSON FUNERAL HOME, INC.  |  |  | 1804 GOOD HOPE RD., S.E.                                |  | WASHINGTON, D.C. 20003   |  | Ft. Meyer, Virginia   |  | JUL 9 1979   |               |  |

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |   |  |  |  |  |                   | REG. NO. 15574   |  |
|--|--|----------------------|--|---|--|--|--|--|-------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Oliver James Minnix</b>   |  |                      |  |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 15 1979</b>         |  |  | 7b. HOUR <b>M</b> |  |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>white</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Aug. 29 1899</b>  |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>79</b>   |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  |                   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>6 15 1979</b>                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George County MD.</b>                      |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Prince George Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Police Officer</b>   |                   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Capital</b>  |  |
| 13a. STATE <b>Md.</b>  |  |                      |  |   |  | 13b. COUNTY <b>P.G.</b>  |  | 13c. CITY OR TOWN<br><b>Dist. Hqts.</b>  |                   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS<br><b>2305 Senator Avenue</b>  |  |                      |  |   |  |  |  |  |                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Leek Minnix</b>   |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |  |  |                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>Yes</b>   |  |                      |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <b>W.W.I</b>  |  | 17. PRESENT ADDRESS<br><b>2607 Boones Lane, Forestville, Md.<br/>Athalie McCarthy, Step-Daughter</b>             |  |  |                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic cardiovascular disease</b><br>4029<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                      |  |   |  |  |  |  |                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>Fracture Cervical Spine - C-4</b>  |  |                      |  |   |  |  |  |  |                   |  |  |
| 19a. DATE OF OPERATION   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |  |                   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>HOUR <b>XX</b> MONTH DAY YEAR<br><b>? P.M. 6/15 1979</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)<br><b>fell in bathroom at home</b> |  |  |                   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>bathroom</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>2305 Senator Drive, District Hts, PG County, MD</b>      |  |  |                   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |                      |  |   |  |  |  |  |                   |  |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan MD</b>   |  |                      |  | TITLE (SPECIFY)<br><b>Assistant</b>   |  |  |  | DATE SIGNED <b>6/16/79</b>   |                   |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>  |  |                      |  | ADDRESS <b>111 Penn Street, Baltimore, MD</b>   |  |  |  |  |                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |                      |  | 23b. DATE <b>6-22-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Russel Duche Mem. Cem</b>   |  |  |                   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>London, Laurel, Ky.</b>                     |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Robt E Wilhelm</b><br>ADDRESS <b>4308 Suitland Rd., Suitland, Md.</b>  |  |                      |  |   |  | 25a. DATE REC'D. BY REGISTRAR 125b. REGISTRAR'S SIGNATURE<br><b>JUN 25 1979</b>                                  |  |  |                   |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |  |   |   |  |
|--|--|---|--|--|--|--|---|---|--|
| FOR<br>1 - STATE<br>REGISTRAR  |  |   |  |  | REG. NO. 79 15575  |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Lillian A Mitchell   |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 6 9 79 2b. HOUR 4 <sup>45</sup> M |  |   |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR 7 30 93  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS   |   | 7. IF UNDER 1 YEAR MONTHS DAYS 8. IF UNDER 24 HRS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George MD.                                    |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Lanham  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Magnolia Gardens Nursing Home |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Auditor                     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov't   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE<br>Md.   |  | 13b. COUNTY<br>P.G.   |  | 13c. CITY OR TOWN<br>Seabrook  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>9509 VanBuren St.  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Unknown   |  |   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Unknown              |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>577-54-5741   |  | 17. INFORMANT<br>Norma M. Anders   |  | ADDRESS Address Same as No # 13e.  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) 3320 Parkinson's Disease<br>DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): |  |   |  |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/22/68, 19, to 6-9-79, that (I) (we) last saw the deceased alive on 6-8-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |  |   |   |  |
| 22b. SIGNATURE<br>Angus W. McLaurin M.D.   |  |   |  |  | 22c. DEGREE<br>M.D.  |  |   | 22d. DATE SIGNED<br>6/9/79  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Angus W. McLaurin, M.D.   |  |   |  |  | 22f. ADDRESS<br>3412 Hamilton St. Hyattsville, Md.                 |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>6-12-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Rock Creek Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Washington D.C.                                   |   |   |  |
| 24. FUNERAL DIRECTOR NAME<br>F. Gasch's Sons F.H. P.A. Hyattsville, Md.  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 13 1979                       |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature] |   |  |

6 1 2 6 1 2 3 4



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15576

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE KNOWN OF DEATH  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <i>William H. MOC KABEE</i>  |  | DATE KNOWN OF DEATH <i>6-7 1979</i>  |  | HOUR <i>4</i>   |  |
| 3. SEX <i>Male</i>  | 4. RACE <i>White</i>   | 5. DATE OF BIRTH <i>11-1-23</i>  | 6. AGE (IN YEARS LAST BIRTHDAY) <i>55</i> YRS.   | IF UNDER 1 YR. MONTHS DAYS  | IF UNDER 24 HRS. HOURS MIN.                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>former George</i>                                    |   |  |
| 10. CITY OR TOWN OF DEATH <i>Cheverly</i>   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Pr. Geo. Gen. Hosp.</i> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Car Inspector</i>   | 12b. KIND OF BUSINESS OR INDUSTRY <i>Wash. Terminal</i>                                      |   |  |
| 13a. STATE <i>Md.</i>   | 13b. COUNTY <i>P.G.</i>  | 13c. CITY OR TOWN <i>Colmar Manor</i>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS <i>3401 40th. Ave.</i>                                    |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Paul Mockabee</i>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Emma Schlorb</i>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>   | 16b. SOCIAL SECURITY NO. <i>578-14-6822</i>  | 17. INFORMANT ADDRESS <i>Address Same as No # 13e.</i>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Hepatic carcinoma</i><br>5715<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |   |  |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>  |  | TITLE (SPECIFY) <i>Deputy</i> MEDICAL EXAMINER   |  | DATE SIGNED <i>6-7-79</i>   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i>   |  | ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md 20031</i>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>   | 23b. DATE <i>6-11-79</i>   | 23c. NAME OF CEMETERY OR CREMATORY <i>Epiphany Ch. Cemetery</i>  | 23d. LOCATION CITY OR TOWN <i>Forestville</i>  | COUNTY <i>P.G.</i>  | STATE <i>Md.</i>                             |
| 24. FUNERAL DIRECTOR NAME <i>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</i>   |  | 25a. DATE REC'D. BY REGISTRAR <i>JUN 11 1979</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>Barney McCroskey</i>                            |  |



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SSA-1-1-1-1

James G. Thompson

• 351 X 07

Historical 8-11-78 Polk County Cemetery Forestville P.D. 101

[illegible]

Items #18a-22a Film G533 7/2/79 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

15577

|  |         |   |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
|--|---------|---|--|---|--|---|--|--|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         | FIRST   |  | MIDDLE  |  | LAST  |  | 2b. DATE KNOWN OF DEATH                      |  | X MONTH                  |  | DAY   |  | YEAR |  | 2b. HOUR |  |
| Bernice  |         |   |  |   |  | Montgomery  |  | 6  |  | 3                        |  | 19    |  | 79   |  | M        |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.  |  | IF UNDER 24 HRS.                             |  | 7c. DATE PRONOUNCED DEAD |  | MONTH |  | DAY  |  | YEAR     |  |
| Female   | Black   | 12 5 78   |  | 6 months  |  |   |  |  |  | 6                        |  | 3     |  | 19   |  | 79       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         | 7b. CITIZEN OF WHAT COUNTRY?                                |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                          |  |       |  |      |  |          |  |
| Maryland   |         | USA   |  | Infant  |  | Prince George's County, MD.   |  |  |  |                          |  |       |  |      |  |          |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION    |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                          |  |       |  |      |  |          |  |
| Cheverly   |         | Prince George's General Hospital                            |  | None  |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| 13a. STATE   |         | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |  |                          |  |       |  |      |  |          |  |
| Maryland   |         | Landover  |  | PG  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 2232 Columbia Place                          |  |                          |  |       |  |      |  |          |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME                                    |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| Cleveland Montgomery   |         | Valerie Morris  |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |         | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| no   |         | None  |  | Bernard Morris-Grandfather  |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | PART I DEATH WAS CAUSED BY:                                 |  | IMMEDIATE CAUSE (a)   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                          |  |       |  |      |  |          |  |
| 7980   |         | Sudden Infant death syndrome                                |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
|  |         | (b)   |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
|  |         | (c)   |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |         |   |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  | 20. AUTOPSY?  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |                          |  |       |  |      |  |          |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         | TITLE (SPECIFY)   |  | DATE SIGNED   |  | 6/4/79  |  |  |  |                          |  |       |  |      |  |          |  |
| ACTUAL SIGNATURE   |         | EXAMINER'S NAME (TYPE OR PRINT)                             |  | ADDRESS   |  | 111 Penn St. Balto., MD.  |  |  |  |                          |  |       |  |      |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE)   |         | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |                          |  |       |  |      |  |          |  |
| Burial   |         | 6/9/79  |  | Harmony Memorial Park   |  | Landover, Maryland  |  |  |  |                          |  |       |  |      |  |          |  |
| 24. FUNERAL DIRECTOR NAME  |         | 25a. DATE OF DEATH BY REGISTRATION                          |  | 25b. REGISTERED   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| John T. Stewart  |         | JUN 11 1979   |  | NE.   |  |   |  |  |  |                          |  |       |  |      |  |          |  |
| Stewart Funeral Home-4001 Benning Road, NE.  |         |   |  |   |  |   |  |  |  |                          |  |       |  |      |  |          |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

VIOLATION

9 12 29 72

RECEIVED

1111 Capitol View Drive

Pattie (unknown)

Henry Williams

120 03 9789 Mrs. Eloise Branch-niece  
1111 Kinnount Road - Richmond, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR   |  |   |  | REG. NO. 15578   |  |   |  |   |  |
| 1 DECEASED NAME (TYPE OR PRINT)<br>ALBERT L. MOORE SR.   |  |   |  | 2a DATE OF DEATH MONTH DAY YEAR<br>06-10-79  |  |   |  | 2b HOUR A.<br>10:31 M.  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>Feb. 22, 1904  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>75 YRS  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGE'S COUNTY MD.                   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>CHEVERLY   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PRINCE GEORGE'S GENERAL HOSPITAL |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Tobacco Farmer      |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Own Farm  |  |
| 13a STATE<br>Maryland  |  |   |  | 13b COUNTY<br>Pr. Geo's  |  | 13c CITY OR TOWN<br>Upper Marlboro  |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>William T. Moore   |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Bertha -- Watson  |  |   |  |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Unk.   |  |   |  | 16b SOCIAL SECURITY NO.  |  | 17 INFORMANT ADDRESS<br>Dorothy B. Moore-Upper Marlboro, Md. 20870                  |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>410-</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Ventricular aneurysm</u>  |  |   |  |  |  |   |  |   |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>1971</u> 19 <u>6-10</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6-4</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |   |  |
| 22b SIGNATURE DEGREE<br><u>Frederic C. Cristofari</u> MD   |  |   |  | 22c DATE SIGNED<br>6/10/79   |  |   |  |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>Frederic C. Cristofari MD  |  |   |  | 22e ADDRESS<br>3327 Superior Lane, Bowie, Md. 20715  |  |   |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b DATE<br>6/14/79   |  | 23c NAME OF CEMETERY OR CREMATORY<br>St. Barnabas Cemetery   |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>Leeland (Pr. Geo's) Md.                   |  |   |  |
| 24 FUNERAL DIRECTOR NAME<br>Richard A. Coleman-Upper Marlboro, Md.   |  |   |  | 25a DATE REC'D. BY REGISTRAR<br>JUN 12 1979  |  | 25b REGISTRAR'S SIGNATURE<br><u>F. J. Kelly</u>                                     |  |   |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15579

1- FOR  
STATE  
REGISTRAR

|  |  |  |   |   |  |  |   |   |  |
|--|--|--|---|---|--|--|---|---|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>MOLLIE MOILLIE MOYLER MOYLER</b>   |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>06 13 79</b>                    |   |  | 2b HOUR<br><b>3:15A M.</b>   |   |   |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Black</b>   |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>06 05 08</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS  |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS HOURS MIN  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>   |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges</b> MD.                               |   |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Clinton</b>   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Southern Maryland Hospital Center</b> |   |   |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |   | 12b KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br><b>Md.</b>   |  | 13b COUNTY<br><b>Pr. George</b>  |   | 13c CITY OR TOWN<br><b>Upper Marlboro</b>   |  | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e STREET ADDRESS<br><b>9705 Dorval Ave.</b>   |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown</b>  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Callie Toney</b>   |   |  |  |   |   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>377-26-2705</b>   |   | 17 INFORMANT ADDRESS<br><b>Julian Moyler-Same as # 13 above</b>   |  |  |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure</b><br><b>4409</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Cardiac arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Systemic arteriosclerosis</b> |  |  |   |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Hypertension</b>  |  |  |   |   |  |  |   |   |  |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |  |
| 21d INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>4-10</b> , 19 <b>79</b> , to <b>6-13</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6-13</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |   |   |  |
| 22b SIGNATURE<br><b>M. Taleghani</b>   |  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c DATE SIGNED<br><b>6-13-79</b>                                     |   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mohammad Taleghani, M.D.</b>  |  |  |   |   | 22e ADDRESS<br><b>3611 Branch Ave., Hillcrest Hgts. Md.</b>  |  |   |   |  |
| 23a BURIAL CREMATION, REMOVAL<br>(SPECIFY)   |  |  | 23b DATE<br><b>6-16-79</b>  |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>LINCOLN MEM. CEM.</b>  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>SUITLAND P.G. Md.</b> |   |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>H.S. WASHINGTON &amp; SONS</b>   |  |  |   |   | ADDRESS<br><b>4925 BURROUGHS AVE., N.E.</b>  |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 15 1979</b>                    |   |  |
|  |  |  |   |   | 25b REGISTRAR'S SIGNATURE<br><b>L. H. H. H.</b>  |  |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1001

Clinton  
Southern Maryland Hospital Center  
St. George Upper Building  
9705 Dorval Ave.  
Prince George's  
Black  
08 05 79  
04 13 79

375-12047  
[Faint, mostly illegible text follows, appearing to be a list or report with multiple lines of information.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  | REG. NO. 15580   |  |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ESTHER <del>XXX</del> A. MURRAY  |  |   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06 11 79                           |  | 2b. HOUR<br>10:50A   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Caucasian  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03 25 94  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>X 85 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 7. IF UNDER 24 HRS<br>HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>WASHINGTON, D. C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE<br>Princess Georges MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Clinton  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Southern Maryland Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>U.S. GOVT.   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Md.   |  |   |  |   |  |  |  |   |  |  |  |
| 13c. CITY OR TOWN<br>Pr. Georges  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 13e. STREET ADDRESS<br>4317 Payne Drive                                   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>VINCENT LUMAS ADAMS   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>CORA O'BRIEN  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  |   |  | 16b. SOCIAL SECURITY NO.<br>517-80-0227<br>XXXXXX   |  | 17. INFORMANT<br>NIECE<br>ARIAN CAMPANELLA   |  | ADDRESS<br>2309 ARTHUR AVE<br>SILVER SPRING, MD.                          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>7991<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.                                 |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>David Abramson</i>   |  |   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>6/11/79   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID ABRAMSON   |  |   |  |   |  | 22e. ADDRESS<br>CLINTON MARYLAND   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |   |  | 23b. DATE<br>6/13/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ARLINGTON NATIONAL   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>ARLINGTON VIRGINIA                |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 12 1979   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Pitney Hardy</i>                         |  |  |  |





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |  |  |                            |  |
|---|--|--|--|--|--|--|--|--|--|----------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | MONTH  |  | DAY  |  | YEAR   |  | 2b. HOUR                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | JUNE   |  | 8:30A M                    |  |
| NANCY   |  | ADELINE  |  | MYERS  |  |  |  |  |  |                            |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | 7. IF UNDER 1 YEAR                           |  | 8. IF UNDER 24 HRS         |  |
| Female  |  | Caucasian  |  | Oct. 25, 1886  |  | 92 YRS   |  | MONTHS                                       |  | DAYS                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |  |  |                            |  |
| No, Carolina  |  | U S A  |  |  |  | Prince George's  |  |  |  | MD.                        |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |                            |  |
| Lanham  |  | Doctors' Hospital of Pr. Geo. Co.  |  | Housewife  |  | Own home   |  |  |  |                            |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13a. COUNTY  |  | 13b. CITY OR TOWN  |  | 13c. STREET ADDRESS  |  |  |  |                            |  |
| Maryland  |  | P. G. Hill Crest Hts   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 4109 Murdock Street  |  |  |  |                            |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |                            |  |
| Pink  |  | Hilton   |  | (Not Known)  |  |  |  |  |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | 10715 Douglas Avenue   |  |  |  |                            |  |
| No  |  | 214-74-0065  |  | H. A. Myers-Silver Spring, Md.   |  | 20902  |  |  |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | PART I. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)  |  | pulmonary Edema, Acute myocardial Infarction                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  | 27 days                    |  |
| 410-  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | (b) Arteriosclerotic cardiovascular Disease.                   |  |  |  |                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | (c) cerebrovascular Accident, left hemiparesis                 |  |  |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |  |  |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |                            |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |                            |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |  |  |  |  |                            |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  | CITY OR TOWN   |  | COUNTY                                       |  | STATE                      |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET   |  |  |  |  |  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from May 10, 1979, to June 7, 1979, that (I) (we) lost saw the deceased alive on June 7, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (d) (did not) view the body after death. |  | 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |  |  |                            |  |
|   |  | C. Hsu   |  | M.D.   |  | 6/7/79   |  |  |  |                            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  |  |  |  |                            |  |
| CHIN-CHUAN HSU  |  | 6905 Baltimore Blvd College park, Md 20740   |  |  |  |  |  |  |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION  |  | CITY OR TOWN                                 |  | COUNTY                     |  |
| Burial  |  | 6/11/79  |  | Evergreen  |  | Monroe-Union-No. Carolina                                      |  |  |  |                            |  |
| 24. FUNERAL DIRECTOR  |  | NAME   |  | ADDRESS  |  | 25a. DATE  |  | 25b. BY REGISTRAR                            |  | 25c. REGISTRAR'S SIGNATURE |  |
| W. W. Chambers Co., Silver Spring, Md.  |  |  |  |  |  | JUN 11 1979  |  |  |  | H. A. Myers                |  |



Item 5,6 per mo. 6/28/79 bal

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15582  
REG. NO.

|  |                            |   |  |   |   |  |   |   |  |
|--|----------------------------|---|--|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Michiyo Nakada</b>   |                            |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>6 21 19 79</b> |   |   | 2b. HOUR<br>M<br><b>7:29</b><br>P<br>M   |   |   |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Oriental</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9 9 56</b>   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>22</b> YRS.   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>6 21 19 79</b>  | 7d. HOUR<br>M<br><b>7:29</b><br>P<br>M  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Japan</b>  |                            | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Japan</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's County, MD.</b>   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |                            | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Prince George's General Hospital (DOA)</b> |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Univ. of Md. School</b>                                 |   |  |
| 13a. STATE<br><b>Maryland</b>  |                            |   | 13b. COUNTY<br><b>Pr. George</b>   |   | 13c. CITY OR TOWN<br><b>Hyattsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Fukuichi Nakada</b>   |                            |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Kikuko Nakada</b>  |   |   | 16. SOCIAL SECURITY NO.<br><b>219-82-9907</b>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>   |                            |   | 16b. SOCIAL SECURITY NO.<br><b>219-82-9907</b>   |   |   | 17. INFORMANT<br>(Guardian) <b>12001 Selfridge Rd. Fred Yamada Wheaton, Md. 20906</b>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple Stab Wounds</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |                            |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                            |   |  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION   |                            |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>? P.M. 6 21 19 79</b>   |                            |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>6 21 19 79</b>   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject stabbed by unknown assailant</b> |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                            |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>wooded area</b>                            |   |   | 21f. LOCATION<br>STREET <b>Near 6808 Highview Ter., Hyattsville, Prince George's, Md.</b><br>CITY OR TOWN COUNTY STATE       |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> |                            |   |  |   |   |  |   |   |  |
| ACTUAL SIGNATURE<br><b>Virginia L. Dolan</b>   |                            |   | TITLE (SPECIFY)<br><b>Assistant</b>  |   |   | DATE SIGNED<br><b>6/22/79</b>  |   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>   |                            |   | ADDRESS<br><b>111 Penn Street</b>  |   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |                            |   | 23b. DATE<br><b>6-27-1979</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan</b>                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Alexandria Fairfax Va.</b>                     |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Warner E. Pumphrey Inc.</b>   |                            |   | ADDRESS<br><b>8434 Ga. Ave. Silver Spring, Md.</b>   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 26 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Anthony McCreedy</b> |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1950



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |             |   |                                 |  |                     |   |  |   |  | REG. NO. 15583                               |  |          |
|--|-------------|---|---------------------------------|--|---------------------|---|--|---|--|--|--|----------|
| 1- FOR STATE REGISTRAR   |             |   |                                 |  |                     |   |  |   |  | 2a. DATE KNOWN OF DEATH                      |  | 2b. HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Geraldine Ruth NEILSON   |             |   |                                 |  |                     |   |  |   |  | ESTIMATED 6-1 1979                           |  | 1979     |
| 3. SEX   | 4. RACE     | 5. DATE OF BIRTH (MONTH DAY YEAR)   | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YR.  | 8. IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD                                      |  | 2d. HOUR  |  | 1979   |  |          |
| Female   | White       | 9-24-21   | 57 YRS.                         |  |                     | 6-1 1979  |  | 1979  |  |  |  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |             | 7b. CITIZEN OF WHAT COUNTRY?  |                                 | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |   |  | MD.  |  |          |
| New Jersey   |             | U.S.A.  |                                 |  |                     | Prince Georges  |  |   |  |  |  |          |
| 10. CITY OR TOWN OF DEATH  |             | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                                 |  |                     | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |          |
| Cheverly   |             | Pr. Geo. Gen. Hosp.   |                                 |  |                     | Housewife   |  | Own Home  |  |  |  |          |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |             |   |                                 |  |                     |   |  |   |  |  |  |          |
| 13a. STATE   | 13b. COUNTY | 13c. CITY OR TOWN   |                                 | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS |   |  |   |  |  |  |          |
| Md.  | P.G.        | Riverdale   |                                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 6227 64th. Ave.     |   |  |   |  |  |  |          |
| 14. FATHER'S NAME (FIRST MIDDLE LAST)  |             |   |                                 | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)   |                     |   |  |   |  |  |  |          |
| James Joseph Egan  |             |   |                                 | Wonona Leszcrynska   |                     |   |  |   |  |  |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |             |   |                                 | 16b. SOCIAL SECURITY NO.   |                     | 17. INFORMANT   |  | ADDRESS   |  |  |  |          |
| No   |             |   |                                 | 139-18-0336  |                     | Jeffrey S. Neilson  |  | Bladensburg, Md.  |  |  |  |          |
| 18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm - cardio-vascular disease</u><br>4370<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |             |   |                                 |  |                     |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><u>Obesity</u>  |             |   |                                 |  |                     |   |  |   |  |  |  |          |
| 19a. DATE OF OPERATION   |             |   |                                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                     |   |  | 20. AUTOPSY?  |  |  |  |          |
|  |             |   |                                 |  |                     |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |             | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |                                 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                     |   |  |   |  |  |  |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |             | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                                 | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |                     |   |  |   |  |  |  |          |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |             |   |                                 |  |                     |   |  |   |  |  |  |          |
| ACTUAL SIGNATURE <u>Augusto P. Rodriguez</u> M.D. <u>Deputy</u>  |             |   |                                 | MEDICAL EXAMINER   |                     |   |  | DATE SIGNED <u>6-2-79</u>   |  |  |  |          |
| EXAMINER'S NAME (TYPE OR PRINT) <u>Augusto P. Rodriguez</u>  |             |   |                                 | ADDRESS <u>5009 Rayburn Ct., Conyers, Md.</u>  |                     |   |  |   |  |  |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |             | 23b. DATE   |                                 | 23c. NAME OF CEMETERY OR CREMATORY   |                     | 23d. LOCATION CITY OR TOWN COUNTY STATE                       |  |   |  |  |  |          |
| Cremation  |             | 6-6-79  |                                 | Ft. Lincoln Crematory  |                     | Brentwood P.G. Md.  |  |   |  |  |  |          |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |             |   |                                 |  |                     | 25a. DATE REC'D. BY REGISTRAR                                 |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |          |
| F. Gasch's Sons F.H. P.A. Hyattsville, Md.   |             |   |                                 |  |                     | JUN 5 1979  |  | <u>Antony M. Brady</u>  |  |  |  |          |

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Grading Top 15.1.00

Final Job 3-2-21

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Joseph

John

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Chas

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Location 6-6-70

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15584

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | JUNE 21, 1979   |  | 2:40 a.m.   |  |
| KATOON NMI NOORY  |  |  |  |   |  |   |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| FEMALE  |  | WHITE  |  | JUNE 15 <sup>1979</sup>   |  | 88 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| TURKEY  |  | USA  |  |   |  | PRINCE GEORGES COUNTY MD.   |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| ANDREWS AFB MD  |  | MALCOLM GROW USAF MEDICAL CENTER   |  | HOUSEWIFE   |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| MARYLAND  |  | PRINCE GEORGES   |  | MARLOW HGTS   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS   |  |   |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  | 3500 EVEREST DR.  |  |   |  |
| GEORGE NMI TAZBAZ (D)   |  | NEJMA NMI MAHMARBACHI (D)  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |
| NO  |  | none   |  | LEON B. NOORY (S)   |  | 3500 EVEREST DR.<br>MARLOW HGTS, MD 20031                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>myocardial infarct - pump failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Jaundice</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>410-</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>20 June 1979</u> , to <u>21 June 1979</u> , that (I) (we) last saw the deceased alive on <u>0240 21 June 79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                    |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Michael O. Daniels</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>21 JUNE 79  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |   |  |
| MICHAEL O. DANIELS, CAPT, USAF, MC  |  | MALCOLM GROW USAF MEDICAL CENTER<br>ANDREWS AFB, MARYLAND 20331  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |
| Burial  |  | 6/25/79  |  | Columbia Gardens Cem.   |  | Arlington Va.   |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |
| G.P. Kalas  |  | 6160 Oxon Hill Rd. Oxon Hill, Md.  |  | JUN 25 1979   |  | <u>History McHenry</u>  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
1805 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR <b>LAURENCE O'DWYER</b>   |  | REG. NO. <b>15585</b>  |  | 2a. DATE OF DEATH MONTH <b>6</b> DAY <b>22</b> YEAR <b>79</b>   |  | 2b. HOUR <b>2:17PM</b>  |  |   |  |
| 3 DECEASED NAME (TYPE OR PRINT) <b>Laurence H. O'Dwyer</b>   |  | 3 SEX <b>Male</b>  |  | 4 RACE <b>White</b>   |  | 5 DATE OF BIRTH MONTH <b>6</b> DAY <b>21</b> YEAR <b>08</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington DC</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>PG County</b> MD.  |  |   |  |
| 10 CITY OR TOWN OF DEATH <b>Clinton</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Southern Maryland Hosp. Center</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Painter</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>   |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>PG</b>  |  | 13c. CITY OR TOWN <b>Forestville</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS <b>4435 Rena Rd #101</b>  |  |
| 14 FATHER'S NAME FIRST <b>Kendall</b> MIDDLE <b></b> LAST <b>O'Dwyer</b>   |  | 15 MOTHER'S MAIDEN NAME FIRST <b>Alice</b> MIDDLE <b></b> LAST <b>Holmead</b>  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>   |  | 16b. SOCIAL SECURITY NO. <b>WWLI</b>   |  | 17 INFORMANT ADDRESS <b>Gladys E. O'Dwyer (wife) Same as #13</b>  |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cardiac arrest</b> (b) <b>hypoxia</b> (c) <b>chronic emphysema</b>  |  |  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>undiagnosed lung lesion</b>  |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION <b>None</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>   |  | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. — 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b></b>  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>  |  | 21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-21-79</b> , to <b>6-22-79</b> , that (I) (we) last saw the deceased alive on <b>6-22-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>John F. Wolski MD</b>  |  | DEGREE <b>MD</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>              |  | 22c. DATE SIGNED <b>6/22/79</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John F. Wolski MD</b>   |  | 22e. ADDRESS <b>3110 Riverdale St. Marlow Heights Md.</b>  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>25 June 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem</b>  |  | 23d. LOCATION CITY OR TOWN <b>Brentwood</b> COUNTY <b>PG</b> STATE <b>Md</b>  |  |   |  |
| 24 FUNERAL DIRECTOR NAME <b>Robert E. Wilhelm</b>  |  | 24b. ADDRESS <b>Funeral Home Inc Suitland, Md</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Robert E. Wilhelm</b>   |  |   |  |

00001 11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  | REG. NO. 15586   |  |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | I. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR                                    |  | 2b. HOUR   |  |  |  |
|  |  | Esther   |  | O'Leary  |  | June 8, 1979  |  | 8:50 A.M.  |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS  |  |
| Female   |  | Cau.   |  | Jan. 1, 1903   |  | 76 YRS.   |  | MONTHS DAYS  |  | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |
| Virginia   |  | U.S.A.   |  |  |  | Prince Georges  |  |  |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |
| Clinton  |  | So. Md. Hospital Center  |  | Homemaker  |  | Own Home  |  |  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?                                 |  | 13e. STREET ADDRESS  |  |
| Maryland   |  | P.G.   |  | Accokeek   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  | Dusty Lane   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |  |  |  |  |
| George Loveless  |  | Flossie Henderson  |  |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |  |  |  |  |
| NO   |  | 577 03 1870  |  | George D. O'Leary  |  | Indian Head, Md.  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Occlusion</u><br>4349<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Hypertension</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>36 hrs<br>Yrs.<br>Yrs. |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-23-</u> 19 <u>76</u> , to <u>JUNE 8</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>JUNE 8</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED  |  |  |  |  |  |
| Thomas L. Fieldson M.D.  |  |  |  |  |  | 6-8-79  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |  |  |  |  |
| Thomas L. Fieldson, M.D.   |  | Brandywine, Maryland 20613   |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |  |  |
| Burial   |  | 6-11-79  |  | Cedar Hill Cem.  |  | Suitland, P.G., Maryland  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME  |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |
| The Hunt Funeral Home  |  | Waldorf, Md.   |  | JUN 13 1979  |  | [Signature]   |  |  |  |  |  |



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                                |  |  |  |   |   |   |   |  | REG. NO. 15587                                      |  |
|---|--------------------------------|--|--|--|---|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Lindsay L. PARLETT</b>   |                                |  | 2b. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6-14-79</b> |  |   | 7b. HOUR  |   |   |  |   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>        | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12-23-2053</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. MONTHS DAYS HOURS MIN.   | IF UNDER 1 YR.   | IF UNDER 24 HRS.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>6-14-79</b>                                   |   |   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Virginia</b>   |                                | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges</b>                               |   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lanham</b>  |                                | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Doctors Hosp. Of Pr. Geo. Co.</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mailer - Wash. Post</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                   |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                                |  |  |  |   |   |   |   |  |   |  |
| 13a. STATE<br><b>Md.</b>  | 13b. COUNTY<br><b>Pr. Geo.</b> | 13c. CITY OR TOWN<br><b>Greenbelt</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   | 13e. STREET ADDRESS<br><b>48D Ridge Road</b>   |   |   |   |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry J. Parlett</b>   |                                |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie J. Ice</b>                                  |  |   |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>  |                                | 16b. SOCIAL SECURITY NO.<br><b>234-32-2103</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>8435 Greenbelt T-2<br/>James P. Parlett Greenbelt, Md.</b>  |   |   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>mitral valve prolapse</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                                |  |  |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Arteriosclerosis</b>  |                                |  |  |  |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |                                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                                |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) |   |   |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |                                |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |   |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                                |  |  |  |   |   |   |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Augusto P. Rodriguez</b>   |                                |  | TITLE (SPECIFY)<br><b>Deputy</b>   |  |   | DATE SIGNED<br><b>6-15-79</b>   |   |   |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Augusto P. Rodriguez, M.D.</b>   |                                |  | 5009 Rayburn Ct., Camp Springs, Md. 20031<br>ADDRESS   |  |   |   |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                                | 23b. DATE<br><b>June 18, 1979</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln</b>   |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood Pr. Geo. Md.</b> |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert G. Beall</b>  |                                |  |  | Funeral Home<br><b>9013 Annapolis Rd. Lanham, Md. Uni</b>  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 19 1979</b> |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCreedy</b> |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73  
(VR A15 ME (5))

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  | REG. NO. 15588   |  |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Richard Marion Paulson</i>   |  |   |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <i>6/26 1979</i> |  |
| 1. SEX <i>Male</i>  |  | 4. RACE <i>White</i>  |  | 5. DATE OF BIRTH<br>MONTH <i>6</i> DAY <i>11</i> YEAR <i>73</i>                   |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <i>56</i> YRS.  |  | IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>                |  | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ohio</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 2c. DATE PRONOUNCED DEAD <i>6/26 1979</i>   |  | 2d. HOUR <i>A</i> M <i>M</i>   |  |
| 10. CITY OR TOWN OF DEATH <i>Cheverly</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince Georges Gen. Hospital</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Printer</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>Wash. Post</i>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD.   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |  |  |   |  |  |  |
| 13a. STATE <i>Maryland</i>  |  | 13b. COUNTY <i>Prince Georges</i>   |  | 13c. CITY OR TOWN <i>W. Hyatts.</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS <i>6632 23rd. Avenue,</i>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <i>Marion</i> MIDDLE <i>C.</i> LAST <i>Paulson</i>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>Helen</i> MIDDLE <i>M.</i> LAST <i>Smith</i> |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>  |  | 16b. SOCIAL SECURITY NO. <i>578-16-5161</i>   |  | 17. INFORMANT ADDRESS <i>Eunice G. Paulson-wife- (same as 13)</i>                 |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary atherosclerotic cardiovascular disease</i><br><i>4292</i><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                 |  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>                 |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>  |  |   |  | TITLE (SPECIFY) <i>MD</i>   |  |  |  | MEDICAL EXAMINER  |  | DATE SIGNED <i>6-26-79</i>   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez</i>   |  |   |  | ADDRESS <i>5809 Bayberry Ct., Camp Springs</i>                                    |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>   |  | 23b. DATE <i>6-29-79</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>                    |  |  |  | 23d. LOCATION<br>CITY OR TOWN <i>Brentwood Pr. Georges</i> COUNTY <i>MD</i> STATE <i>MD</i> |  |  |  |
| 24. FUNERAL DIRECTOR NAME <i>Warner E. Pumpfrey, Inc</i>  |  |   |  | ADDRESS <i>8434 Ga. Ave., S.S. Md.</i>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <i>JUL 2 1979</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>Robert McQuay</i>  |  |

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REEL NO. 100 200

WILKINSON

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. GIVE PAGE 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15589  
REG. NO.

|   |         |  |                   |  |                     |                                      |  |
|---|---------|--|-------------------|--|---------------------|--------------------------------------|--|
| 1- FOR STATE REGISTRAR  |         | 20. DATE KNOWN OF DEATH  |                   | MONTH DAY YEAR   |                     | 2b HOUR                              |  |
| DECEASED NAME (TYPE OR PRINT)   |         | FIRST MIDDLE LAST  |                   | 6 26 19 79   |                     | 11:41 P                              |  |
| CONNIE F. PHILLIPS  |         |  |                   |  |                     |                                      |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR.  | 8. IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD             |  |
| female  | black   | 4 17 61  | 18 YRS.           |  |                     | 6 26 19 79                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |                   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                     | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |
| INDIANA   |         | UNITED STATES  |                   |  |                     | PRINCE GEORGE'S COUNTY MD.           |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                     | 12b. KIND OF BUSINESS OR INDUSTRY    |  |
| SUITLAND  |         | Prince George's Hospital   |                   | STUDENT  |                     | NONE                                 |  |
| 13a. STATE  |         | 13b. CITY OR TOWN  |                   | 13d. INSIDE CITY LIMITS?   |                     | 13e. STREET ADDRESS                  |  |
| MARYLAND  |         | PRINCE GEORGE  |                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                     | 2216 GAYLORD DRIVE                   |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |                   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |                     | 16b. SOCIAL SECURITY NO.             |  |
| WILLIAM   |         | BETTY  |                   | 17. INFORMANT  |                     | ADDRESS                              |  |
| FIRST MIDDLE LAST   |         | FIRST MIDDLE LAST  |                   | MRS. BETTY PHILLIPS  |                     |                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                   |  |                     |                                      |  |
| PART I DEATH WAS CAUSED BY: <b>Electrocution</b>  |         |  |                   |  |                     |                                      |  |
| IMMEDIATE CAUSE (a) <b>9250</b>   |         |  |                   |  |                     |                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |                   |  |                     |                                      |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:   |         |  |                   |  |                     |                                      |  |
| (b)   |         |  |                   |  |                     |                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |                   |  |                     |                                      |  |
| (c)   |         |  |                   |  |                     |                                      |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |  |                   |  |                     |                                      |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                   | 20. AUTOPSY?   |                     |                                      |  |
|   |         |  |                   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                     |                                      |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |                     |                                      |  |
|   |         | 8:30 P.M. 6 26 19 79   |                   | possibly electrocuted by TV set  |                     |                                      |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |                   | 21f. LOCATION  |                     |                                      |  |
|   |         | home   |                   | 2216 Gayford Drive Prince George's Maryland  |                     |                                      |  |
| 22a. I certify that I took charge of the remains described above, held on   |         | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |                   |  |                     |                                      |  |
| death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         | TITLE (SPECIFY)  |                   | DATE SIGNED  |                     |                                      |  |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i>   |         | M.D. Assistant   |                   | MEDICAL EXAMINER   |                     | 6/27/79                              |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         | ADDRESS  |                   |  |                     |                                      |  |
| Margarita A. Korell, M.D.   |         | 111 Penn Street  |                   |  |                     |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY   |                     | 23d. LOCATION                        |  |
| BURIAL  |         | 7-3-79   |                   | HARMONY  |                     | LANDOVER                             |  |
|   |         |  |                   |  |                     | COUNTY MARYLAND STATE                |  |
| 24. FUNERAL DIRECTOR  |         | 25a. DATE REC'D. BY REGISTRAR  |                   | 25b. REGISTRAR'S SIGNATURE   |                     |                                      |  |
| NAME ADDRESS  |         | JUN 27 1979  |                   | <i>Pickering</i>   |                     |                                      |  |
| JOHN T. RHINES CO., 3015 12th ST., N.E., D.C.   |         |  |                   |  |                     |                                      |  |

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Medical examiner notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | REG. NO. 15390  |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>JOSEPH WALTER PORTER   |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>JUNE 30, 1979   |  | 2b. HOUR<br>9:35P M  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>March 6, 1921   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>58 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGE COUNTY MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>LANHAM   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>DOCTORS' HOSPITAL OF P.G. COUNTY |  |   |  | 12a. Retired<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Engineer Technician  |  | 12b. Research<br>INDUSTRY<br>Navy Lab.   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |  |   |  |   |  | 13b. COUNTY<br>Prince Georges   |  | 13c. CITY OR TOWN<br>Riverdale   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Wylie Porter  |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Geneva B. Grant  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW 11  |  | 17. INFORMANT<br>ADDRESS<br>JOSEPHINE PORTER 459-0364<br>6604 OLIVER ST. HYATTSVILLE, MD.   |  | 18. (Wife)  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Auto myocardial Infarction<br>410 - DUE TO, OR AS A CONSEQUENCE OF<br>(b) Coronary Heart Disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Arteriosclerotic Cardiovascular Disease.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>20 hrs |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Diabetes mellitus uncontrolled.  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 30, 19 79, to June 30, 19 79, that (I) (we) lost saw the deceased alive on June 30, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>C. Hsu M.D.   |  |   |  | DEGREE  |  | ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>6/30/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHI N-CHUAN HSU  |  |   |  | 22e. ADDRESS<br>6905 Baltimore BLVD Collyer park, md 20740  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>7/3/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Maryland Veterans Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cheltenham P.G. Md.   |  |  |  |
| 24. FUNERAL DIRECTOR<br>Francis Gasch's Sons Funeral Home, P.A.<br>Hyattsville, Maryland  |  |   |  | 25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br>JUL 5 1979  |  |   |  |  |  |

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |  |  |   |   |  |   |  | REG. NO. 15591 |  |
|--|-------------------------|---|--|--|---|---|--|---|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John H. PRICE Jr.</b>   |                         |   |  |  |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>6-18 1979</b>   |  | 2b. HOUR <b>M</b>   |  |                |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6-21-68</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS. <b>10</b>                          | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN  | IF UNDER 24 HRS.  | 2c. DATE PRONOUNCED DEAD <b>6-18 1979</b>   |  | 2d. HOUR <b>M</b>   |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges</b> MD.                               |  |   |  |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Landover</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Prince Georges Hosp.</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>student</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>school</b>                            |  |                |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                         |   |  |  |   |   |  |   |  |                |  |
| 13a. STATE<br><b>Md.</b>   |                         | 13b. COUNTY<br><b>Prince George</b>   |  | 13c. CITY OR TOWN<br><b>Landover</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>unk.</b>  |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Howard Price Sr.</b>   |                         |   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cynthia McDonald</b>                        |  |   |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>no</b>   |                         |   | 16b. SOCIAL SECURITY NO.<br><b>235-08-8634</b>                             |  |   | 17. INFORMANT ADDRESS<br><b>John Price Sr., RFD, Shenandoah Jct.</b>                            |  |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Browning</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last<br><b>9108</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). |                         |   |  |  |   |   |  |   |  |                |  |
| 19. DATE OF OPERATION  |                         |   |  |  |   |   |  |   |  |                |  |
| 20. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                         |   |  |  |   |   |  |   |  |                |  |
| 21. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                         |   |  |  |   |   |  |   |  |                |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>6-17 1979</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Fell off a plywood raft</b>               |   |  |   |  |                |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>Pond</b> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>W. 112 Green Village, Willow Hill Drive, East Prince Georges, Md.</b> |   |  |   |  |                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |                         |   |  |  |   |   |  |   |  |                |  |
| ACTUAL SIGNATURE<br><b>Augusto P. Rodriguez</b>  |                         |   | TITLE (SPECIFY)<br>M.D. <b>Deputy</b>                                      |  | MEDICAL EXAMINER  |   | DATE SIGNED <b>6-18-79</b>                     |   |  |                |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>Augusto P. Rodriguez</b>   |                         |   | ADDRESS <b>5009 Layburn Ct., Camp Springs, Md. 20747</b>                   |  |   |   |  |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>burial</b>  |                         |   | 23b. DATE<br><b>6/21/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Duffields Cemetery</b>   |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>RFD, Shenandoah Junction</b> |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Melvin T. Strider Co., Charles Town, W. Va.</b>  |                         |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 25 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>R. L. ...</b> |   |  |                |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 15592   |  |   |  |  |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR                               |  |
| ULYSSES  |  | D.   |  | PRITCHETT   |  | 06   |  | 21 79  |  |
| 3 SEX  |  | 4 RACE   |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7b. HOUR   |  |
| Male   |  | Black  |  | 09 12 14  |  | 64   |  | 9:55P.M.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  | 10b. HOUR  |  |
| Virginia   |  | U.S.A.   |  |   |  | Prince Georges   |  | MD.  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Clinton  |  | SOUTHERN MARYLAND HOSPITAL CENTER  |  | Retired   |  | Coal Miner   |  |  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS  |  |
| Md.  |  | Pr. Geo.   |  | Oxon Hill   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 1724 Taylor Avenue   |  |
| 14 FATHER'S NAME   |  | 15 MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |
| James A. Pritchett   |  | Janie Armstrong  |  | Yes   |  | 235-07-2970A   |  | Zelma L. Pritchett Same as #13                                 |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____  |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
| 2031 Plasma cell leukemia  |  |  |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  |  | DUE TO, OR AS A CONSEQUENCE OF (b) _____   |  | DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mos.            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| Hypercalcemia + Renal failure  |  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-26-79, to 6-21-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE Kai-Yin Yewng MD.   |  | 22c. DATE SIGNED 6-22-79  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                             |  |
| Kai-Yin Yewng MD.  |  | 6525 Belcrest Rd #460 Hyattsville MD 20782   |  | Burial  |  | 6/26/79  |  | Cheltenham Md. Vet. Cheltenham, P.G. Md.                       |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  | 26. FUNERAL HOME NAME  |  | 27. ADDRESS  |  |
| Geo Funeral Home Inc.  |  | JUN 28 1979  |  | [Signature]   |  | 6633 Old Alexander Ferry Rd. Clinton Md.                                       |  |  |  |





## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15593

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Myrtle L. Pryor</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>6</b> DAY <b>2</b> YEAR <b>79</b> 3:15A M                      |  |  |
| 3 SEX <b>Female</b>   | 4 RACE <b>White</b>  | 5. DATE OF BIRTH<br>MONTH <b>April</b> DAY <b>7</b> YEAR <b>1884</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>95</b> YRS.                        |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Missouri</b>   | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George</b> MD.         |  |
| 10 CITY OR TOWN OF DEATH<br><b>Hyattsville</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Carroll Manor Nursing Home</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>          |  | 12b KIND OF BUSINESS OR INDUSTRY<br><b>---</b> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |  |  |
| 13a STATE<br><b>Maryland</b>  | 13b COUNTY<br><b>PG</b>  | 13c CITY OR TOWN<br><b>Seat Pleasant</b>   | 13d INSIDE CITY LIMITS?<br><b>X</b> YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e STREET ADDRESS<br><b>314 Zelma Avenue</b>                            |  |
| 14 FATHER'S NAME<br>FIRST <b>Gibson</b> MIDDLE <b>L</b> LAST <b>Taylor</b>  |  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST <b>Susan</b> MIDDLE <b>Stacey</b> LAST <b>Stacey</b>        |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b SOCIAL SECURITY NO.<br><b>491-05-2025</b>  |  | 17 INFORMANT<br>ADDRESS<br><b>Helen S. Opstad (dau) Same as #13</b>      |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE CONGESTIVE HEART FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>ART SC/CAR REN VAS DIS</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>CEREBRATISCHEMIA PERIPHERAL VAS. DIS</b><br>Approximate interval between onset and death: <b>1 WK</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <b>YEARS</b> |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>CEREBRATISCHEMIA PERIPHERAL VAS. DIS</b>  |  |  |  |  |  |
| 19a DATE OF OPERATION<br><b>6/11/79</b>   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ART SC/CAR REN VAS DIS</b>   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                        |  |
| 22a. I certify that (I) <b>Frederick W. Schneider MD</b> attended the deceased from <b>AUG 6, 19 77</b> , to <b>6/2 19 79</b> , that (I) <b>did</b> saw the deceased alive on <b>6/11 19 79</b> and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>did not</b> view the body after death.   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Frederick W. Schneider MD</b>  |  | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>6/2/79</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FREDERICK W. SCHNEIDER</b>  |  | 22e. ADDRESS<br><b>201-8 ST NE DC 20002</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>June 6, 79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maple Park Cemetery</b>         |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Springfield Mo.</b>  |  | 24. FUNERAL DIRECTOR<br>NAME <b>Robert E. Wilhelm</b> ADDRESS <b>Suitland, Md</b>  |  |  |  |
| 25a. DATE RECD. BY REGISTRAR<br><b>JUN 11 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Brady</b>   |  |  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



1 2 3 4 5 6 7 8 9 10 11 12



Handwritten text, mostly illegible due to blurring and bleed-through. Some words like "The" and "and" are visible.

Handwritten text at the bottom of the page, including what appears to be a date "1/1/19" and other illegible markings.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 5 5 9 4

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |   |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>PHYLLIS ANN PUGH</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>06 15 79</b>                 |   |  | 2b. HOUR<br><b>4:55A.M.</b>   |  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 19 48</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>31</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><b>YRS</b>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges</b> MD.                               |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Clinton</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Southern Maryland Hospital Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  |   |  | 13b. CITY OR TOWN<br><b>Pr. Georges Forrestville</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13d. STREET ADDRESS<br><b>3227 Walters Lane</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Parley A. Lambert</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ruby P. York</b>  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>  |  | 17. INFORMANT<br><b>Ronald C. Pugh Sr.</b>  |  | ADDRESS<br><b>Same as #13</b>   |  |  |  |  |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic cervical carcinoma</b><br><b>1809</b><br>Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): |  |   |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>June 14 1979</b> to <b>June 14 1979</b> that (1) we last saw the deceased alive on <b>June 14 1979</b> and that in (my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) see the body after death.   |  |   |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  |   | 22c. ADDRESS<br><b>625 Belcrest Rd Hyattsville</b>                     |   |  | 22d. DATE SIGNED<br><b>6/18/79</b>  |  |  |  |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HA. DAK</b>  |  |   | 22f. ADDRESS<br><b>625 Belcrest Rd Hyattsville</b>                     |   |  | 22g. DATE SIGNED<br><b>6/18/79</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>6/19/79</b>  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Trinity Memorial Garden</b>                            |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Charles Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lee Funeral Home Inc.</b>   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 18 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |
| 26. ADDRESS<br><b>6633 Old Alexander Ferry Rd. Clinton Md.</b>   |  |   |  |   |  |   |  |  |  |  |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



1 2 3 4 5 6 7 8 9 10 11 12

| NAME                | ADDRESS                           | PHONE | DATE |
|---------------------|-----------------------------------|-------|------|
| CLINTON             | Southern Maryland Hospital Center |       |      |
| DR. GEORGE B. BROWN | 3337 Western Lane                 | X     |      |
| DR. J. J. BROWN     | 1000 N. York                      |       |      |
| DR. J. J. BROWN     | 1000 N. York                      |       |      |
| DR. J. J. BROWN     | 1000 N. York                      |       |      |

1 2 3 4 5 6 7 8 9 10 11 12

added info g534 8/16/79 g3

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79 15595  
REG. NO.1. FOR  
STATE  
REGISTRAR

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Baby Girl QUICK</i>        |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>6/20/79</i>  |  | 2b. HOUR<br><i>0430 AM</i>   |  |
| 3 SEX<br><i>Female</i>   | 4 RACE<br><i>Black</i>                      | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>6 20 79</i>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><i>0</i> YRS.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>         | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i> | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><i>Terry E. Pick m.d.</i> MD. |  |
| 10 CITY OR TOWN OF DEATH<br><i>Cheverly</i>                          |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Prince Georges Gen Hospital</i>            |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)     |  |
| 13a. STATE<br><i>Maryland</i>  |   | 13b. COUNTY<br><i>Prince George</i>  |  | 13c. CITY OR TOWN<br><i>Fairmount</i>                                |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST                                |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Vanessa Diane Quick</i>  |  | 13e. STREET ADDRESS<br><i>5345 Sheriff Rd Apt 101</i>                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT<br>ADDRESS<br><i>Mother Same as Above</i>              |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*7651*

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
*1 hour*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>0200 AM 20 June 79</i> , to <i>0430 20 June 79</i> , that (I) (we) last saw the deceased alive on <i>0430 20 June 79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Terry E. Pick m.d.</i>   |  |  |  | DEGREE   |  | 22c. DATE SIGNED<br><i>6/20/79</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Terry E. Pick m.d.</i>  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  |
|   |  |  |  | 22e. ADDRESS   |  |   |  |

|  |  |                             |  |  |  |  |  |
|--|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>cremation</i>                 |  | 23b. DATE<br><i>7/18/79</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Prince George's Hospital, Cheverly, P.G. Maryland</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE       |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Raleigh Cline, Cheverly, Maryland</i> |  |                             |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JUL 23 1979</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12021



12021

12021

X



FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15596

|  |  |   |   |  |   |  |  |   |  |  |
|--|--|---|---|--|---|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br><b>LILLIAN C. RAMEY</b>  |  |   | 2a DATE OF DEATH<br>MONTH DAY YEAR<br><b>06 21 79</b>                 |  |   | 2b HOUR<br><b>2:30P.M.</b>   |  |   |  |  |
| 3 SEX<br><b>Female</b>   |  | 4 RACE<br><b>Black</b>  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br><b>02 07 21</b>   |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |  |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 9b CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges County MD.</b>  |  |   |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Clinton</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTHERN MARYLAND HOSPITAL CENTER</b> |   |  |   | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>  |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a STATE<br><b>Maryland</b>   |  |   | 13b COUNTY<br><b>Charles</b>  |  | 13c CITY OR TOWN<br><b>Accokeek</b>                     |  | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e STREET ADDRESS<br><b>Rt. 2 Box 70, 20607</b> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>RICHARD E. PROCTOR</b>   |  |   | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JENNIE SIMMONS</b> |  |   | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |   |  |  |
| 16b SOCIAL SECURITY NO.<br><b>577-24-5818</b>  |  |   | 17 INFORMANT<br><b>EDNA GREENFIELD</b>                                |  |   | ADDRESS<br><b>101 WOODLAND RD. INDIAN HEAD, MD.</b>  |  |   |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Metastatic Cancer</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.        |  |   |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |  |   |  |  |   |  |  |
| 19a DATE OF OPERATION  |  |   | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |   | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  |   | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>June 20</b> , 19 <b>79</b> , to <b>June 21</b> , 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>June 21</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |  |   |  |  |   |  |  |
| 22b SIGNATURE<br><b>Rosario Fernandez</b>  |  |   | DEGREE<br><b>M.D.</b>   |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c DATE SIGNED<br><b>6/22/79</b>                |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Rosario Fernandez</b>   |  |   | 22e ADDRESS<br><b>Indian Head, Maryland 20640</b>                     |  |   |  |  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |   | 23b DATE<br><b>6-25-79</b>  |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>ST. CHARLES</b> |  |  | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CLYMONT CHARLES MD.</b>   |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br><b>LEDA THORNTON</b>  |  |   | ADDRESS<br><b>Rt. 1 Box 15 Pomonkey, MD.</b>                          |  |   | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 26 1979</b>   |  | 25b REGISTRAR'S SIGNATURE<br><b>Kurtz McCreedy</b>  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 15597  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | June 26, 1979   |  | 9.09 P  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Male  |  | White  |  | Dec 14, 1904  |  | 74  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| N. Y.   |  | USA  |  |   |  | Prince Georges Co. MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Lanham  |  | Doctors Hospital of Pr. Geo  |  | Co. acct/auditor  |  | US Gov't  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland  |  | Pr. Geo's  |  | Lanham  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  |
| FIRST MIDDLE LAST   |  | FIRST MIDDLE LAST  |  | No  |  | 212-38-3324   |  |
| Clifford R. Reed  |  | Grace Francis  |  | 17. INFORMANT   |  | ADDRESS   |  |
|   |  |  |  | Gladys M. Reed, (wife)  |  | same as above   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| PART I. DEATH WAS CAUSED BY   |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (a)   |  |  |  | Respiratory Failure   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  | (b) Cardio - Pulmonary Failure  |  |   |  |
|   |  |  |  | (c) Septicemia  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |
| Intestinal obstruction, Abscess.  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
|   |  | P.M. 19  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
|   |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 4, 1979, to June 26, 1979, that (I) (we) lost saw the deceased alive on June 26, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED  |  |
| AMIR S. BANISAR, M.D.   |  | M.D.   |  |   |  | June 27, 1979   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |   |  |
|   |  | 6490 Landover Rd., Cheverly, Md.   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |
| Cremation   |  | 6/28/79  |  | Metropolitan Crematory  |  | Alexandria, Virginia  |  |
| 24. FUNERAL DIRECTOR NAME   |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |
| Francis Gasch's Sons, PA Hyattsville, Md.   |  |  |  | JUL 2 1979  |  | L. B. Bandy   |  |

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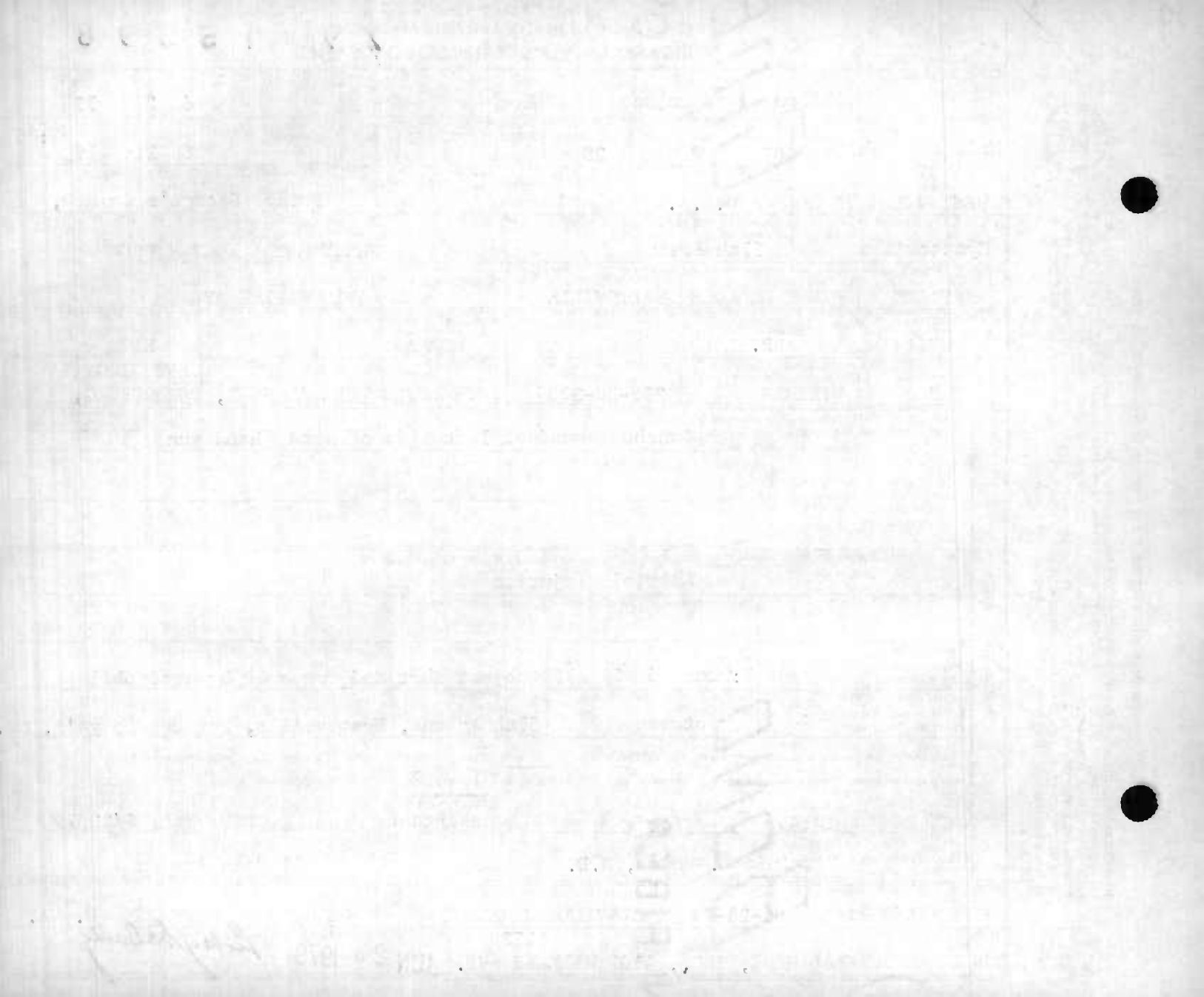
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 WITH YOUR OFFICE. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |  |   |   |  |  |   |                            |  | REG. NO. 15598 |  |
|--|-------------------------|--|---|---|--|--|---|----------------------------|--|----------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>William Dolman Reel</b>   |                         |  |   |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 21 19 79</b> |   | 2b. HOUR <b>8:00</b>       |  |                |  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>07 08 50</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>28 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>6 21 19 79</b>                                 |   | 2d. HOUR <b>A</b>          |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WEST VIRGINIA</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's County, MD.</b>                   |   |                            |  |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hyattsville</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>57th Avenue</b> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SHEET METAL WORKER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>UNKNOWN</b> |                            |  |                |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                         |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>4710 NAPLES AVENUE</b>   |   |                            |  |                |  |
| 13a. STATE<br><b>MARYLAND</b>  |                         | 13b. COUNTY<br><b>PRINCE GEORGES</b>   |   | 13c. CITY OR TOWN<br><b>BELTSVILLE</b>  |  |  |   |                            |  |                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM P. REEL</b>   |                         |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>NORMA HAWK</b>  |  |  |   |                            |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>YES</b>  |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>VIETNAM</b>  |   | 17. INFORMANT<br><b>SCHAEFFER FUNERAL HOME, PETERSBURG,</b>   |  | ADDRESS <b>WEST VIRGINIA</b>   |   |                            |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot Wound of left side of head (hand gun)</b><br>9650<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF  |                         |  |   |   |  |  |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Multiple Injuries</b>  |                         |  |   |   |  |  |   |                            |  |                |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |   |                            |  |                |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>7:00xx 6 21 19 79</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Subject shot and run over by automobile</b>                             |  |  |   |                            |  |                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b>   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>57th Avenue, Hyattsville, Prince George's, Md</b>   |  |  |   |                            |  |                |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |  |   |   |  |  |   |                            |  |                |  |
| ACTUAL SIGNATURE<br><i>Virginia L. Dolan</i>   |                         | M.D. <b>Assistant</b>  |   |   |  | MEDICAL EXAMINER   |   | DATE SIGNED <b>6/22/79</b> |  |                |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Virginia L. Dolan, M.D.</b>   |                         | ADDRESS<br><b>111 Penn Street</b>  |   |   |  |  |   |                            |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>REMOVAL/BURIAL</b>   |                         | 23b. DATE<br><b>06-24-79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MAYSVILLE CEMETERY</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>MAYSVILLE GRANT W. VA.</b>                  |   |                            |  |                |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HUBBARD FUNERAL HOME, INC.,</b>   |                         | ADDRESS<br><b>21229 4107 WILKENS AVE.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 20 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |                            |  |                |  |

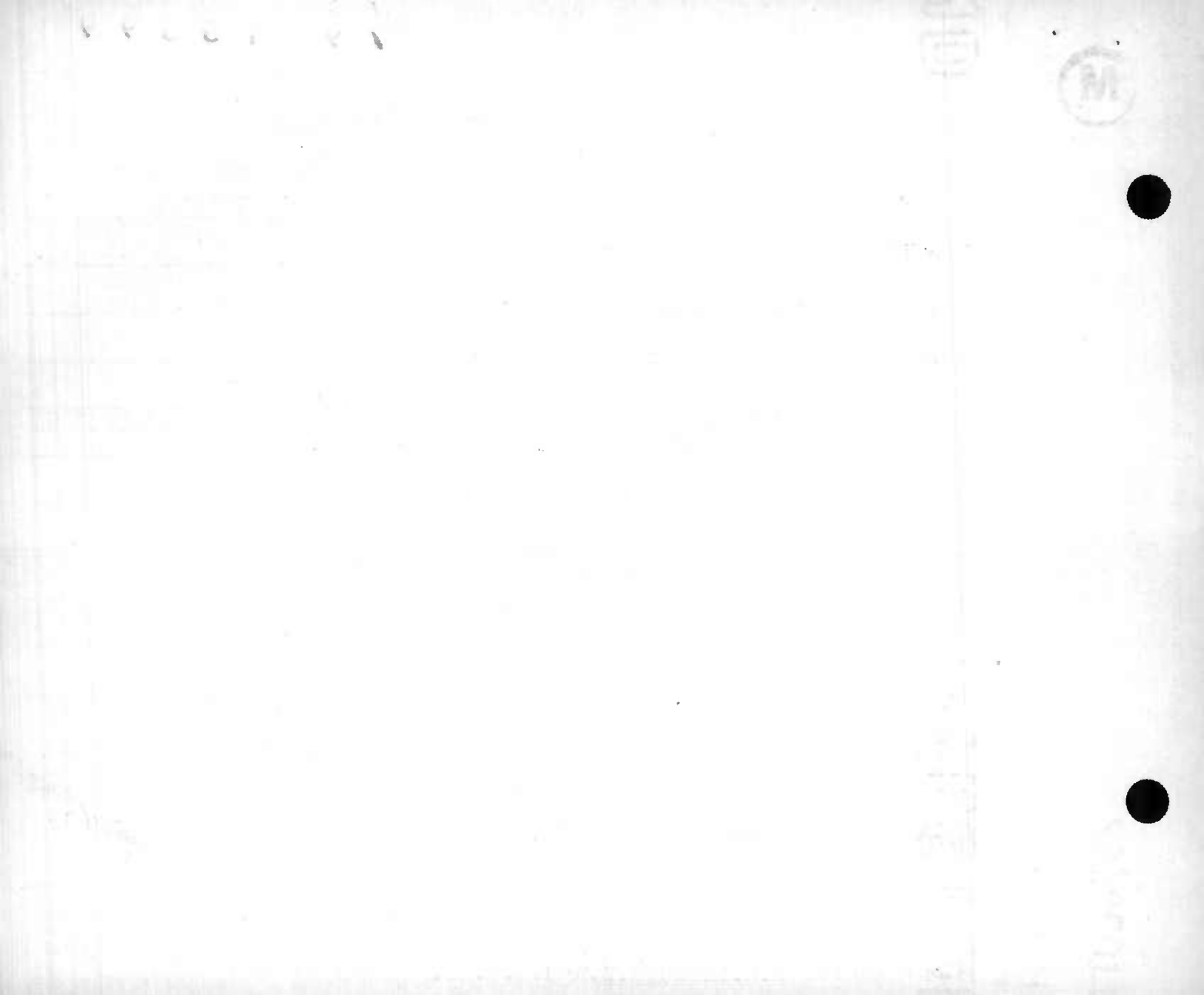


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |   |  |   |  |
|--|--|---|--|---|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 7. 15599  |  | REG. NO.  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>MATTHEW F. REGAN   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06 24 79                        |   |   | 2b. HOUR<br>11:20 A M  |   |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>October 4, 1921   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGE'S COUNTY MD.   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>CHEVERLY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PRINCE GEORGE'S GENERAL HOSPITAL |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Engineer   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Singer-Link   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md   |  |   | 13b. COUNTY<br>PG  |   | 13c. CITY OR TOWN<br>Hyattsville                          |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>6701 Wells Parkway |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Matthew F. Regan   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Conway           |   |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  |   | 16b. SOCIAL SECURITY NO.<br>WWII                                       |   | 17. INFORMANT<br>Same as above                            |  | ADDRESS<br>Mary M. Regan (Wife)   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Intercerebral Hemorrhage</u><br>431-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertension</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 days<br>1/2 year |  |   |  |   |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |   |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-18-79</u> , 19____, to <u>6-24-79</u> , 19____, that (I) (we) lost saw the deceased alive on <u>6-23-79</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Robert Gerwin</u>   |  |   | DEGREE<br>M.D.   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>6/24/79  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Robert Gerwin M.D.</u>   |  |   | 22e. ADDRESS<br><u>9811 MARLARD Drive Laurel, Md 20811</u>             |   |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |   | 23b. DATE<br>6/27/79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cheltenham Cemetery |  | 23d. LOCATION (CITY OR TOWN)<br>Cheltenham PG Md.   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Hires/Rinaldi  |  |   | ADDRESS<br>F.H. 11800 N.H. Ave. S.S. Md.                               |   |   | 25a. DATE REC'D. BY REGISTRAR<br>JUN 28 1979   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony M. Cready</u>   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

MEDICAL CERTIFICATION

| <div style="display: flex; justify-content: space-between;"> <div> <p>FOR<br/>1 - STATE<br/>REGISTRAR</p> </div> <div> <p>STATE OF MARYLAND<br/>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br/>CERTIFICATE OF DEATH</p> </div> <div> <p>99 15600</p> </div> </div>  |  |  |   |   |  |  |  |   |  |  |  |
|--|--|--|---|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Florence M. Reilley</b>   |  |  |   |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>6 24 79</b>   |  |   | 2b. HOUR<br><b>30</b>                              |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>6-10-1894</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b>   |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Pr. Geo.</b>  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pr. Geo. Gen. Hosp.</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>      |  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |   |   |  |  |  |   |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Pr. Geo.</b>   |   | 13c. CITY OR TOWN<br><b>Hyattsville</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>Farragut 5503 - Paragut St.</b>   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John Schneider</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Tremper</b>   |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO<br><b>578-14-3632</b>  |   | 17. INFORMANT ADDRESS<br><b>Margaret Wilson - 6216-Marietta Ave., Baltimore, Md.</b>  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:<br><b>1579</b> IMMEDIATE CAUSE (a) <b>Carcinomatous</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Pancreatic carcinoma</b><br>(c) <b>Pancreatic carcinoma</b> |  |  |   |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>6-15-79</b>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>EXPLORATORY-BIOSAY</b> |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)           |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June 23 19 79</b> to <b>June 24 19 79</b> , that (I) (we) last saw the deceased alive on <b>June 23 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                               |  |  |   |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE <b>Don B. Cameron</b> DEGREE <b>MD</b>  |  |  |   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>6-25-79</b>                 |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DON B. CAMERON</b>   |  |  |   |   |  | 22e. ADDRESS   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>6/27/1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cem.</b> |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Wash., D.C.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Nalley's F.H. Inc. Mt. Rainier, Md.</b>  |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 29 1979</b>  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Barney McLeod</b> |  |  |



U U U U

27-1-2011

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                        |   |  |   |                  |   |                          |   |  |  |  |
|--|------------------------|---|--|---|------------------|---|--------------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM Alfred RENN Jr.</b>  |                        |   |  |   |                  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>6 30 1979</b> |                          | 2b. HOUR<br><b>M</b>  |  | REG. NO. <b>15601</b>                        |  |
| 3 SEX<br><b>MALE</b>   | 4 RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 16, 1955</b>  | 6. AGE (IN YEARS<br>LAST BIRTHDAY)<br><b>23 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>6 30 79</b>  | 7d. HOUR<br><b>3:53A</b> |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington D.C.</b>  |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's County, MD</b>                                   |                          |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |                        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Prince George's Gen. Hosp. (DOA)</b> |  |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Warehouse</b>                           |                          | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hechinger's</b>                             |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Prince Georges</b> 13c. CITY OR TOWN <b>Hyattsville</b>  |                        |   |  |   |                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |                          | 13e. STREET ADDRESS<br><b>3735 Warner Avenue</b>                                    |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William A. Renn Sr.</b>   |                        |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bernice Cash</b>  |                  |   |                          |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>  |                        | (IF YES, GIVE WAR OR DATES)<br><b>Vietnam</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214 70 1623</b>  |                  | 17. INFORMANT<br><b>William A. Renn Sr. Father</b>  |                          | ADDRESS<br><b>Same as # 13</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple injuries</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>(c) _____  |                        |   |  |   |                  |   |                          |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                        |   |  |   |                  |   |                          |   |  |  |  |
| 19a. DATE OF OPERATION   |                        |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                  |   |                          | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                        | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>2:30xx 6 30 1979!</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>driver in auto/fixed object impact</b>                                  |                  |   |                          |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                        | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>street</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Central Avenue Largo P.G. MD</b>  |                  |   |                          |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                        |   |  |   |                  |   |                          |   |  | TITLE (SPECIFY)<br><b>Deputy Chief</b>       |  |
| ACTUAL SIGNATURE<br><i>Thomas D. Smith</i>   |                        |   |  | M.D. <b>Deputy Chief</b>  |                  |   |                          | DATE SIGNED<br><b>7/1/79</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Thomas D. Smith, M.D.</b>  |                        |   |  | ADDRESS<br><b>111 Penn St. Balto., Md.</b>  |                  |   |                          |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                        | 23b. DATE<br><b>7/3/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |                  |   |                          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood P.G. Md.</b>             |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland</b>   |                        |   |  |   |                  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 5 1979</b>  |                          | 25b. REGISTRAR'S SIGNATURE<br><i>Barry McBratney</i>                                |  |  |  |

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1957, Dec. 15, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 8

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Figure 1. 3

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 15602   |  |   |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR             |  |
| ELIZABETH   |  | E. E.  |  | RICHARDS  |  |  |  | 06 13 79                                     |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | 7. HOUR                                      |  |
| Female  |  | Caucasian  |  | 03 11 03  |  | 76 YRS.  |  | 7:20 PM                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |  |  |
| Pennsylvania  |  | USA  |  |   |  | Prince Georges County  |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  |  |  |
| Clinton   |  | SOUTHERN MARYLAND HOSPITAL CENTER  |  |   |  |  |  |  |  |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS?                                       |  | 13d. STREET ADDRESS                          |  |
| Maryland  |  | Prince Georges Temple Hills  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 85 Temple Hills Rd   |  | 20032  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |  |  |  |  |  |
| Jacob W. Berninger  |  | Ella M. ?  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |  |  |  |  |
| No  |  | 579-30-2064  |  | 6701 Botetourt Drive Carl Richards, Son, Temple Hills, Md.  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 410-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u>   |  |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe Atherosclerosis</u>  |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypertension, Diabetes, Gout, Ventricular fibrillation, Complete Heart Block</u>   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 6/7/79  |  | Transvenous Pacemaker for HT CK  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
|   |  | P.M. NA 19   |  | NA  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
|   |  | NA   |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/5/79</u> , 19 <u>79</u> , to <u>6/13</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6/13/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |  | 22c. DATE SIGNED   |  |  |  |
| Richard McConnaughey M.D.   |  |  |  |   |  | 6/13/79  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |  |  |
| Burial  |  | 6-18-79  |  | Md. Nat. Me. Park   |  | Laurel, Maryland   |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                                     |  |  |  |
| Robt E Wilhelm  |  | 4308 Suitland Rd., Suitland, Md.   |  | JUN 19 1979   |  | Anthony McCreedy   |  |  |  |

20001 PA

EXHIBIT A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |  |   |  |   |  | REG. NO. 15603  |  |
|---|--|---|---|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DORIS ANN RICHESON</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>06</b> DAY <b>15</b> YEAR <b>79</b> |   |  | 2b. HOUR<br><b>3:06 A.M.</b>  |  |   |  |   |  |
| 3 SEX<br><b>Female</b>  |  | 4 RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>02</b> DAY <b>11</b> YEAR <b>54</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>25</b> YRS   |  | IF UNDER 1 YEAR<br>MONTHS <b>---</b> DAYS <b>---</b>  |  | IF UNDER 74 HRS.<br>HOURS <b>---</b> MIN. <b>---</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges</b> MD                                 |  |   |  |   |  |
| 10 CITY OR TOWN OF DEATH<br><b>Clinton</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Southern Maryland Hospital Center</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md</b> 13b. COUNTY <b>Pr. Georges</b> 13c. CITY OR TOWN <b>Suitland</b>  |  |   |   |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>3508 Parkway Terrace</b>  |  |   |  |
| 14 FATHER'S NAME<br>FIRST <b>Alfred</b> MIDDLE <b>W.</b> LAST <b>Anderson</b>   |  |   |   |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>---</b> LAST <b>Long</b>                |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>---</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Don D. Richeson (spouse) Same As #13</b>                         |  |   |  |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4229</b> IMMEDIATE CAUSE (a) <b>Viral Myocarditis.</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>---</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |   |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>11 days</b>  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Diabetes Mellitus</b>  |  |   |   |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>---</b>  |  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>---</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>---</b> P.M. <b>---</b> 19 <b>79</b>  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>---</b>  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>---</b>  |  |   |  | 21f. LOCATION<br>STREET <b>---</b> CITY OR TOWN <b>---</b> COUNTY <b>---</b> STATE <b>---</b> |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>6/4</b> 19 <b>79</b> , to <b>6/15</b> 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>6/14</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (I) (did not) view the body after death.                |  |   |   |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Andre L. Laz</b>   |  |   |   | DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>6/15/79</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Andre L. Laz M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>9401 Indian Head Hwy., Oxon Hill, Md.</b>  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   |   | 23b. DATE<br><b>June 19-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington National</b>                                |  | 23d. LOCATION<br>CITY OR TOWN <b>Suitland</b> COUNTY <b>PG</b> STATE <b>Md</b>                |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Robert E. Wilhelm</b> ADDRESS <b>Suitland, Md.</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 19 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Hickory</b>  |  |   |  |   |  |

00001488



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO. 79 15604  |  |   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Roscoe McKnight Roach   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6-11-79 |   |  | 3b. HOUR<br>7:45 AM   |  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>August 8, 1924  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>54 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wash. D.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Pr. Geo. Co. MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>University Park   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6701 Queens Chapel Rd. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Navy Dept.                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Gov't.   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  | 13b. COUNTY<br>P.G.  |  | 13c. CITY OR TOWN<br>Univ. Park   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>6701 Queens Chapel Rd.  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Roscoe McKnight Roach  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pauline A. Moran   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>W.W.II 579-20-8131   |  | 17. INFORMANT<br>JUNE M. ROACH<br>ADDRESS Address Same as No # 13e.   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma Lung with</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced Abdominal Metastases</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) (1)  |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Aug 10</u> 19 <u>78</u> to <u>June 11</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>June 10</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Richard L. Whelton M.D.</u><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |  |  |   |  | 22c. DATE SIGNED<br><u>June 11, 1979</u>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RICHARD L. WHELTON  |  |  |  |   |  | 22e. ADDRESS<br>7100 Baltimore College Park Maryland  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>6-15-79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Veteran Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Cheltenham P.G. Md.                               |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>F. Gasch's Sons F.H. P.A. Hyatts. Md.  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 18 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Henry McBrady</u>   |  |

UCC 1 4 4



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (1))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15605

|  |  |   |  |   |  |   |  |  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>MARK Daniel ROBERTSON |  |   |  |   |  |  |  |   |  | 7a. DATE OF DEATH KNOWN OF ESTI-MATED<br>MONTH DAY YEAR<br>6 19 79                              |  | 7b. HOUR<br>5:00 P.M.                        |  |
| 3. SEX<br>male   |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 2 58   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>20 YRS.                  |  | IF UNDER 1 YR.<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN                                       |  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>6 19 79   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  |   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George's County MD                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Chesapeake  |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Prince George's General Hospital |  |   |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>plumber                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>plumber |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE CITY COUNTY<br>MD Calvert Chesapeake  |  |   |  |   |  |   |  |  |  | 13b. CITY OR TOWN<br>Chesapeake                                     |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13d. STREET ADDRESS<br>PO Box 481            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Milton A. Robertson  |  |   |  |   |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Barbara E. Shipman |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>no   |  |   |  | 16b. SOCIAL SECURITY NO.<br>214-72-3717   |  |   |  | 17. INFORMANT<br>Barbara Robertson same as # 13  |  |   |  | ADDRESS   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <b>Craniocerebral and cervical spine injuries</b><br>8162<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |   |  |   |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY<br>HOUR MONTH DAY YEAR<br>11:40 6 17 79<br>P.M.   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>driver of motorcycle which lost control                                 |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>roadway  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>Dalyrymple Road Sunderland, Maryland  |  |   |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |   |  |   |  |   |  |  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>Margarita A. Korell  |  |   |  | TITLE (SPECIFY)<br>M.D. Assistant   |  |   |  | MEDICAL EXAMINER   |  |   |  | DATE SIGNED<br>6/20/79  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Margarita A. Korell, M.D.   |  |   |  | ADDRESS<br>111 Penn Street  |  |   |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>burial  |  |   |  | 23b. DATE<br>june 22, 1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Southern Home Gardens |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dunkirk Cal. Maryland |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Rausch Funeral Home  |  |   |  | ADDRESS<br>Owings Md. 20836   |  |   |  | 25a. DATE RECD. BY REGISTRAR<br>JUN 25 1979  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>R. M. Brady   |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 5 6 0 6

REG. NO.

|  |  |  |   |  |   |
|--|--|--|---|--|---|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |   | 2b. HOUR   |   |
| I. DECEASED NAME (TYPE OR PRINT)   |  | MONTH DAY YEAR   |   | 1:13 P.M.  |   |
| DORA R. ROBINSON   |  | 06 11 79   |   |  |   |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. IF UNDER 1 YEAR   |   |
| Female   | Black  | Jan. 3, 1893   | 86 YRS.   | MONTHS DAYS HOURS MIN  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |   |
| Maryland   | U.S.A.   |  | PRINCE GEORGE'S COUNTY MD.  |  |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |   |
| CHEVERLY   | PRINCE GEORGE'S GENERSL HOSPITAL   | Housewife  | Home  |  |   |
| 13a. STATE   |  | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS                           |
| Maryland   | Prince Geo.  | College Pk.  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 5015 Lakeland Road   |   |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |   | 16. ADDRESS  |   |
| Robert - Brooks  |  | Annie -  |   | (Unknown)  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |   |
| No   |  | 577-34-1423  |   | Leon Robinson-5010 Pierce Ave.-College Pk., Md.                                |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN DEATH AND EXAMIN |
| IMMEDIATE CAUSE (a) 4019 Cordiac Arrest  |  |  |   |  | 1 day   |
| DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis  |  |  |   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension  |  |  |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |   |
| Pneumothorax, Gastroenteritis, Diabetes mellitus   |  |  |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?  |   |
|  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
|  |  | P.M. 19  |   |  |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |
|  |  |  |   |  |   |
| 22. I certify that (I) (this hospital) attended the deceased from 6/14/79, 19 to 6/11, 1979, that (I) (we) last saw the deceased alive on 6/11, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |
| 22b. SIGNATURE   |  | DEGREE   |   | 22c. DATE SIGNED   |   |
| Henry A. Wise Jr.  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                          |   | 6/12/79  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |   |  |   |
| Henry A. Wise Jr.  |  | Lanham, Md   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY   |   |
| Burial   |  | June 16, 1979  |   | Maryland National  |   |
| 23d. LOCATION CITY OR TOWN   |  | 23e. COUNTY  |   | 23f. STATE   |   |
| Laurel, P.G. Co., Maryland   |  |  |   |  |   |
| 24. FUNERAL DIRECTOR NAME  |  | ADDRESS  |   | 25a. DATE REC'D. BY REGISTRAR  |   |
| Chambers Funeral Home  |  | Riverdale, Maryland  |   | JUN 19 1979  |   |
|  |  |  |   | 25b. REGISTRAR'S SIGNATURE   |   |
|  |  |  |   | History McCreedy   |   |

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Medical Examiner Notified  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be procured within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death. The law requires that the death certificate be procured within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death.

DHMH - 16 50M 7/77  
(VR A 15(4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7915608

FOR  
1 - STATE  
REGISTRAR

|  |  |  |  |   |                                 |  |
|--|--|--|--|---|---------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>GEORGE W. ROGERS   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 15 1979                        |   | 2b. HOUR<br>11:50A <sub>M</sub> |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12-2-1919   |                                 |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>59 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 7. IF UNDER 24 HRS<br>HOURS MIN.  |                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wash., D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George's MD.  |  |  | 10. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Plumber |   |                                 |  |
| 11. CITY OR TOWN OF DEATH<br>Lanham  |  |  | 12. KIND OF BUSINESS OR INDUSTRY<br>Const. Co.                             |   |                                 |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS<br>Md. Pr. Geo. New Carrollton 8321 - Stanwood St.  |  |  |  |   |                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clarence L. Rogers   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Bessie M. Heartley        |   |                                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) Yes   |  | 16b. SOCIAL SECURITY NO.<br>WW II 579-10-2644  |  | 17. INFORMANT<br>ADDRESS<br>Charlotte M. Rogers (Wife) Above  |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>POST OP. ESOPHAGO-GASTROSTOMY</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>BLEEDING PEPTIC ESOPHAGITIS</u><br>5301<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |                                 |  |
| 19a. DATE OF OPERATION<br>6/14/79  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>BLEED IN FROM STOMACH  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-19</u> , 19 <u>79</u> , to <u>6-15</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>6-15</u> , 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |                                 |  |
| 22b. SIGNATURE<br>Haluk B. Boneval, M.D.   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>6/15/79   |                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Haluk B. Boneval, M.D.  |  | 22e. ADDRESS<br>6001 Landover Rd., Cheverly, Md. 20785   |  |   |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>6-18-79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln Cem.  |                                 |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brentwood Pr. Geo. Md.   |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Nalley's F.H. Inc. Mt. Rainier, Md.  |  |   |                                 |  |
| 25a. DATE REC'D. BY REGISTRAR<br>JUN 19 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |                                 |  |

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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Items #18--22a Film 0533 7/27/79 re STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15609  
 REG. NO.

|  |        |                 |   |                |                  |   |  |  |
|--|--------|-----------------|---|----------------|------------------|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |        |                 | 2a. DATE OF DEATH   |                |                  | 2b. HOUR  |  |  |
| ROSE MARIE ROSE  |        |                 | 6 5 19 79   |                |                  | 4:45 A  |  |  |
| 3 SEX  | 4 RACE | 5 DATE OF BIRTH | 6 AGE (IN YEARS)  | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD  |  |  |
| female   | white  | 2/9/37          | 42  |                |                  | 6 5 19 79   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |        |                 | 7b. CITIZEN OF WHAT COUNTRY?                                |                |                  | 9 BALTIMORE CITY OR COUNTY OF DEATH   |  |  |
| Wash. D.C.   |        |                 | U.S.A.  |                |                  | Prince George's County  |  |  |
| 10 CITY OR TOWN OF DEATH   |        |                 | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION     |                |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  |  |
| Camp Springs   |        |                 | Andrews AFB Hospital  |                |                  | Housewife   |  |  |
| 13a. STATE   |        |                 | 13b. COUNTY   |                |                  | 13c. CITY OR TOWN   |  |  |
| Md.  |        |                 | P.G.  |                |                  | Camp Springs  |  |  |
| 14. FATHER'S NAME  |        |                 | 15. MOTHER'S MAIDEN NAME                                    |                |                  | 17. INFORMANT   |  |  |
| Jerry C. Lanahan   |        |                 | Margaret J. Perrygo   |                |                  | Kathleen Rose Same as #13   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |        |                 | 16b. SOCIAL SECURITY NO.                                    |                |                  | 17. INFORMANT   |  |  |
| No   |        |                 | None  |                |                  | 213-34-5543   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |        |                 |   |                |                  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute combined amitriptyline and alcohol   |        |                 |   |                |                  |   |  |  |
| 9504 DUE TO, OR AS A CONSEQUENCE OF Intoxication   |        |                 |   |                |                  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:  |        |                 |   |                |                  |   |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |        |                 |   |                |                  |   |  |  |
| (c)  |        |                 |   |                |                  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1   |        |                 |   |                |                  |   |  |  |
| 19a. DATE OF OPERATION   |        |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                |                  | 20. AUTOPSY?  |  |  |
|  |        |                 |   |                |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |        |                 | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR                |                |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |
|  |        |                 | P.M. 19   |                |                  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |        |                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                |                  | 21f. LOCATION   |  |  |
|  |        |                 |   |                |                  | CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |        |                 |   |                |                  |   |  |  |
| ACTUAL SIGNATURE   |        |                 | TITLE (SPECIFY)   |                |                  | DATE SIGNED   |  |  |
| Margarita A. Korell  |        |                 | Assistant   |                |                  | 6/6/79  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |        |                 | ADDRESS   |                |                  |   |  |  |
| Margarita A. Korell, M.D.  |        |                 | 111 Penn Street   |                |                  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |        |                 | 23b. DATE   |                |                  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  |
| Burial   |        |                 | 6/8/79  |                |                  | Wash. National Cem.   |  |  |
| 23d. LOCATION CITY OR TOWN   |        |                 | COUNTY  |                |                  | STATE   |  |  |
| Suitland   |        |                 | P.G.  |                |                  | Md.   |  |  |
| 24. FUNERAL DIRECTOR'S NAME  |        |                 | 25a. DATE REC'D. BY REGISTRAR                               |                |                  | 25b. REGISTRAR'S SIGNATURE  |  |  |
| Funeral Home, Inc.   |        |                 | JUN 12 1979   |                |                  | Dorothy McCreedy  |  |  |
| 6633 Old Alexander Ferry Rd. Clinton Md.   |        |                 |   |                |                  |   |  |  |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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## MEDICAL EXAMINER NOTIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |  |  |
|---|--|---|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 1 5 6 1 0   |  |   |  | REG. NO.   |  |   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  | FIRST   |  | MIDDLE  |  | LAST   |  | 2a DATE OF DEATH MONTH DAY YEAR   |  | 2b HOUR A M                                  |  |
| NEEL  |  | K   |  | SARALKAR  |  |  |  | 06 23 79  |  | 8:30 A M                                     |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH MONTH DAY YEAR  |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7a IF UNDER 1 YEAR MONTHS DAYS  |  | 7b IF UNDER 24 HRS HOURS MIN                 |  |
| Male  |  | white   |  | July 29, 1978   |  | 11 Months  |  |   |  |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |  |  |
| Maryland  |  | U S A   |  |   |  | PRINCE GEORGE'S COUNTY MD.   |  |   |  |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b KIND OF BUSINESS OR INDUSTRY             |  |
| CHEVERLY  |  | PRINCE GEORGE'S GENERAL HOSPITAL  |  |   |  |  |  | None  |  | None   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |   |  |  |  |   |  |  |  |
| 13a STATE   |  | 13b COUNTY  |  | 13c CITY OR TOWN  |  | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e STREET ADDRESS  |  |  |  |
| Md  |  | Pro Georges   |  | Seabrook  |  |  |  | 9913 Good Luck Road   |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  |   |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |  |  |
| Kishor Saralkar   |  |   |  | Chhaya Kulkarni   |  |  |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |   |  | 16b SOCIAL SECURITY NO.   |  | 17 INFORMANT ADDRESS   |  |   |  |  |  |
| no  |  |   |  | none  |  | Kishor Saralkar Seabrook, Md.  |  |   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY:  |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| IMMEDIATE CAUSE (a) 3300  |  |   |  |   |  |  |  |   |  | 11 MONTHS                                    |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |   |  |   |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |   |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |   |  |  |  |
| NONE  |  |   |  |   |  |  |  |   |  |  |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| NONE  |  |   |  |   |  |  |  |   |  |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |
|   |  | P.M. 19   |  |   |  |  |  |   |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f LOCATION STREET   |  | CITY OR TOWN   |  | COUNTY  |  | STATE  |  |
|   |  |   |  |   |  |  |  |   |  |  |  |
| 22a I certify that (1) (this hospital) attended the deceased from JULY 29, 1978, to JUNE 23, 1979, that (1) (we) lost saw the deceased alive on JULY 23, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |   |  |  |  |
| 22b SIGNATURE   |  |   |  | DEGREE  |  |  |  | 22c DATE SIGNED   |  |  |  |
| A. P. Wyner MD  |  |   |  |   |  |  |  | 6/23/79   |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  | 22e ADDRESS   |  |  |  |   |  |  |  |
| STEVEN P. WYNER MD  |  |   |  | PRINCE GEORGES GENERAL HOSPITAL   |  |  |  |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b DATE  |  | 23c NAME OF CEMETERY OR CREMATORY   |  | 23d LOCATION CITY OR TOWN  |  | COUNTY  |  | STATE  |  |
| Cremation   |  | June 25, 1979   |  | Ft Lincoln Cemetery   |  | Brentwood Pro Georges  |  | Md.   |  |  |  |
| 24 FUNERAL DIRECTOR NAME  |  |   |  | ADDRESS   |  |  |  | 25a DATE RECEIVED BY REGISTRAR 25b REGISTRAR'S SIGNATURE  |  |  |  |
| F. Gasch's Sons P A   |  |   |  | Hyattsville, Maryland   |  |  |  | JUN 26 1979 [Signature]   |  |  |  |

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Pulse



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15611

FOR  
1. STATE  
REGISTRAR

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Florence McD Sazama</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>6</b> - DAY <b>29</b> - YEAR <b>79</b> |   |  | 2b. HOUR<br><b>4:15A</b>   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>31</b> YEAR <b>1899</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mitchellville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Villa Rosa N. H.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME.</b>  |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Pr. Ge/</b>  |  | 13c. CITY OR TOWN<br><b>Upper Marlboro</b>  |  | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                            |  |
| 14. FATHER'S NAME<br>FIRST <b>Hugh</b> MIDDLE <b>H</b> LAST <b>McDevitt</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>FLORENCE</b> MIDDLE <b>D</b> LAST <b>Smith</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(yes, no or UNKNOWN) <b>no</b>  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>2ND-54-79-814-54-7086</b>  |  | 17. INFORMANT<br>NAME <b>Rev. A. Dal Balcon</b> ADDRESS <b>3800 Lottsford Vista Rd. Mitchellville, Md. 20716</b>                     |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA (aspirative)</b><br>4409<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Chronic Brain Spasm</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic Brain Spasm</b> |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-31</b> , 19 <b>75</b> , to <b>6-26</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6-26</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>6-29/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ciro A. Montanez MD</b>   |  | 22e. ADDRESS<br><b>3308 Dodge Park Rd Landover Md</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  | 23b. DATE<br><b>7/3/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON NAT. CEM.</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>ARLINGTON</b> COUNTY <b>VA.</b> STATE <b>VA.</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Taylor E. H. Taylor</b> ADDRESS <b>Annapolis, Md.</b>   |  | 25a. DATE RECD. BY REGISTRAR<br><b>JUL 3 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br>  |  |  |  |

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15612

|   |  |   |  |   |  |  |   |  |   |  |
|---|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SCHAEFER, ELIZABETH AGNES</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>6</b> DAY <b>2</b> YEAR <b>79</b>        |   |  | 2b. HOUR<br><b>6:00 A.M.</b>   |   |  |   |  |
| 3 SEX<br><b>FEMALE</b>  |  | 4 RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>12</b> YEAR <b>06</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS                                     |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>PRINCE GEORGE'S</b> MD.                   |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>CLINTON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTHERN A.D. HOSPITAL CENTER</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |   |  |
| 13a. STATE<br><b>MD</b>   |  |   | 13b. COUNTY<br><b>P.G.</b>   |   | 13c. CITY OR TOWN<br><b>CLINTON</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>5713 ALAN DRIVE</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>Jacob</b> MIDDLE <b>Kline</b> LAST  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Minnie</b> LAST <b>Van Howling</b>        |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>577-52 0199</b>                         |   | 17. INFORMANT<br>ADDRESS<br><b>George E. Schaefer Same as #13</b>              |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br><b>1749</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CA. OF BREAST METASTASIS</b><br>(c) <b>TO LIVER AND LUNG</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHERE AT WORK <input type="checkbox"/> HOT WHERE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>5/27</b> 19 <b>79</b> to <b>6/2</b> 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>6/1</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (that) (I) did not see the body after death.  |  |   |  |   |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>J.H. Ruback</b> M.D.   |  |   |  |   | 22c. DATE SIGNED<br><b>6/2/79</b>  |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |   | 22f. ADDRESS   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>6/5/79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington National Cemetery</b>      |  | 23d. LOCATION<br>CITY OR TOWN <b>Suitland P.G. Md.</b> COUNTY STATE   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Lee Funeral Home Inc.</b> ADDRESS <b>6633 Old Alexander Ferry Rd. Clinton, Md.</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 8 1979</b>                             |  | 25b. REGISTRAR'S SIGNATURE<br><b>Barney McCready</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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entirely local.

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 5 6 1 3

|   |  |  |  |   |  |   |   |  |  |
|---|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Andrew F Scherer</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>06 15 79</b>                 |   |  | 2b. HOUR<br><b>8:45</b> am  |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 10, 1909</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Nebraska</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges County</b> MD.                |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Laurel</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Greater Laurel Beltsville Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Lithographer</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Dept of Agr.</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>P.G. Co.</b>   |   | 13c. CITY OR TOWN<br><b>Beltsville</b>                       |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Scherer</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Klara Kolke</b>    |   |  | 13e. STREET ADDRESS<br><b>4713 Prince George's Ave.</b>                                 |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-44-3000</b>   |  | 17. INFORMANT<br><b>M. Tracey Scherer</b>   |  | ADDRESS<br><b>same as #13</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Spontaneous Adenocarcinoma - Lung</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)          |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                       |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May 25<sup>th</sup> 1979</b> , to <b>June 15<sup>th</sup> 1979</b> , that (I) (we) last saw the deceased alive on <b>6-15</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death.                                    |  |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>B. G. Maneywala</b>  |  |  |  |   |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>6/15/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>B. G. Maneywala MD</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>314 Second St Laurel Md 20810</b>                                    |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>6/18/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland P.G. Co. Md.</b>                      |  |  |
| 24. FUNERAL DIRECTOR<br><b>FLECK LAUREL FUNERAL HOME, INC.</b><br><b>7601 Sandy Spring Rd. Laurel, Md 20810</b>   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 20 1979</b>                                     |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |   |  |
|---|--|--|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 1 5 6 1 4<br>REG. NO.  |  |  |  |   |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR                               |  | 2b. HOUR A M  |  |
| EUGENE  |  | S.   |  | SEBASTIAN  |  |   |  | 06 02 79   |  | 7:30 A M  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR MONTHS DAYS                                    |  | IF UNDER 24 HRS HOURS MIN                                       |  |
| Male  |  | White  |  | March 11 1885  |  | 94 YRS.   |  |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |   |  |
| Wash. D.C.  |  | U.S.A.   |  |  |  | PRINCE GEORGE'S COUNTY MD.  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |
| CHEVERLY  |  | EXTENDED CARE FACILITY   |  |  |  |   |  | Electrician  |  | Retired   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |   |  |
| D.C.  |  |  |  | Wash, DC   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 4800 Avondale Rd.  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |   |  |  |  |   |  |
| Walter B. Sebastian   |  |  |  | Unknown  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |   |  |
| No  |  | 578-05-8377A   |  | Bernard E. (Son) Sebastian   |  | 6100 Westchester Park Dr. Prince George's College Park, Md. 20740   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio Respiratory Failure</u><br>4140<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 Day<br>2 Days |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Pneumonia, Right lung.</u>   |  |  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |   |  |
|   |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |   |  |
|   |  | P.M. 19  |  |  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |   |  |
|   |  |  |  |  |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAR 31</u> 19 <u>79</u> to <u>JUNE 2</u> 19 <u>79</u> that (I) (we) last saw the deceased alive on <u>JUNE 2</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |  |  |   |  |
| <u>Samuel J. N. Sugar MD</u>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 6/2/79   |  |   |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |  |  |   |  |
| SAMUEL J. N. SUGAR MD   |  | 4637 EASTERN AVE WASHINGTON DC 20015   |  |  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |   |  |
| Burial  |  | June 5, 1979   |  | Glenwood Cemetery  |  | Washington D.C.   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |
| Hines/Rinaldi F.H.  |  | 11800 New Hampshire Ave. Silver Spring, Md. 20904  |  | JUN 6 1979   |  | <u>Anthony McCready</u>   |  |  |  |   |  |



FILE 1 2 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |  |   |   |   |  |
|---|--|---|---|---|--|---|---|---|--|
| 1. FOR STATE REGISTRAR  |  |   |   |   | REG. NO. 15615   |   |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Andrew Lee Selby</i>  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR <i>6-20-79</i> 240  |   |   |   |  |
| 3 SEX <i>Female</i>   |  |   |   |   | 2b. HOUR <i>2:48 PM</i>  |   |   |   |  |
| 4 RACE <i>White</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <i>April 13, 1918</i>   |   |   | 6 AGE (IN YEARS LAST BIRTHDAY) <i>61</i>   |   | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.                   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Oklahoma</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges MD.</i>                     |   |   |  |
| 10. CITY OR TOWN OF DEATH <i>Brandywine</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Brandywine-Waldorf Clinic</i> |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>contract negotiator</i>   |   | 12b. KIND OF BUSINESS OR INDUSTRY <i>Naval Systems Com.</i> |   |  |
| 13a. STATE <i>Md.</i> 13b. COUNTY <i>Pr. Geo.</i> 13c. CITY OR TOWN <i>Brandywine</i>   |  |   |   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>George M. Holland, Sr.</i>   |  |   |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bessie Lee Dalby</i>   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>   |  |   |   |   | 16b. SOCIAL SECURITY NO. <i>442-16-9075</i>  |   |   |   |  |
| 17. INFORMANT ADDRESS <i>4332 East Pima Tucson, Arizona</i>   |  |   |   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cancer</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1809</i> |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>         |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8-6</i> , 19 <i>66</i> , to <i>6-20</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>6-15</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. |  |   |   |   |  |   |   |   |  |
| 22b. SIGNATURE <i>Richard H. Dobson</i> DEGREE <i>MD</i>  |  |   |   |   | 22c. DATE SIGNED <i>6-20-79</i>  |   |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Richard H. Dobson, M.D.</i>  |  |
| 22e. ADDRESS <i>Brandywine, Maryland 20613</i>  |  |   |   |   | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>  |   |   |   |  |
| 23b. DATE <i>6-23-79</i>  |  |   |   |   | 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>  |   |   |   |  |
| 23d. LOCATION CITY OR TOWN <i>Suitland</i> COUNTY <i>Pr. Geo.</i> STATE <i>Md.</i>  |  |   |   |   | 24. FUNERAL DIRECTOR NAME <i>Huntt Funeral Home, Waldorf, Md.</i> ADDRESS  |   |   |   |  |
| 25a. DATE OF REGISTRATION <i>JUN 22 1979</i>  |  |   |   |   | 25b. REGISTRY SIGNATURE <i>Andrew Selby</i>  |   |   |   |  |

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April 12, 1918

Prince George

Prince George

Prince George

Prince George  
1001 1001 1001

Richard H. Johnson, M.D.

Richard H. Johnson, M.D.

Richard H. Johnson, M.D.

Medical examiner notified

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 7 9 1 5 6 1 6<br>REG. NO.  |  |   |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HAROLD FRANCIS SHEEHAN  |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>6/22/79                                       |  | 2b. HOUR<br>6:15A M  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>June 6 1906   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Mass.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGES MD.                           |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>RIVERDALE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>EUGENE LELAND MEMORIAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Accounting       |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Auto Dealership   |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>P.G.  |  | 13c. CITY OR TOWN<br>Hyattsville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3900 Hamilton St. Apt. 204  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Thomas F. Sheehan  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Louise Delaney  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WW 2  |  | 17. INFORMANT<br>ADDRESS<br>Anne G. Sheehan Same as # 13  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Shock<br>1541<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Adenocarcinoma of rectum with metastases<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Hepatomegaly with massive ascites<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 months |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 21, 1979, to June 22, 1979, that (I) (we) last saw the deceased alive on June 22, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (I did not) view the body after death.   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>C. Hsu<br>M.D.   |  |  |  | DEGREE<br>M.D.  |  |  |  | 22c. DATE SIGNED<br>6/22/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>CHIN-CHUAN HSU  |  |  |  | 22e. ADDRESS<br>6905 Baltimore BLVD Collegepark md 20740  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>6-25-79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Ft. Lincoln Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Brentwood, P.G., Md.                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>F. Gasch's Sons, P.A. Hyattsville, Md.   |  |  |  | 25a. DATE RECEIVED BY REGISTRAR<br>JUN 26 1979  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |



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FRANCIS SHEDDEN

PRINCE GEORGES

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                                   |  |  |  |   |   |  |  | REG. NO. 15617   |  |
|---|--|-----------------------------------|--|--|--|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  |                                   |  |  |  |   |   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Frances Elizabeth SHIRLEY</b>   |  |                                   |  |  |  |   |   |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>6-5 1979</b> |  |
| 3. SEX <b>Female</b> 4. RACE <b>White</b> 5. DATE OF BIRTH <b>7-7-12</b> 6. AGE (IN YEARS) <b>66</b> YRS. 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 7c. DATE PRONOUNCED <b>6-5 1979</b>  |  |                                   |  |  |  |   |   |  |  | 2b. HOUR <b>2:30</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>   |  |                                   | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> |  |  |
| 10. CITY OR TOWN OF DEATH <b>Cheverly</b>   |  |                                   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pr. Geo. Gen. Hosp.</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>       |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |                                   |  |  |  |   |   |  |  |  |  |
| 13a. STATE <b>Md.</b>   |  | 13b. COUNTY <b>Prince Georges</b> |  |  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13d. STREET ADDRESS <b>5404 Emerson Street</b>                         |  |  |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Neil Clemmer</b>   |  |                                   |  |  | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Ida Kell</b>   |   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>  |  |                                   |  |  | 16b. SOCIAL SECURITY NO. <b>214-48-7825</b>                    |   | 17. INFORMANT <b>Robert H. Shirley</b> ADDRESS <b>228 Oakwood Ave. Edgewater, Md.</b> |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b)<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF   |  |                                   |  |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>Diabetes mellitus, Obesity, Aspiration</b>  |  |                                   |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                                   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |   |   |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                                   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>    |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)         |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |                                   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)    |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                                   |  |  |  |   |   |  |  |  |  |
| ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>  |  |                                   |  |  | TITLE (SPECIFY) <b>Deputy</b>                                  |   | MEDICAL EXAMINER  |  | DATE SIGNED <b>6-5-79</b>                                  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez</b>   |  |                                   |  |  | ADDRESS <b>5209 Rayburn Ch., Camp Springs, Md.</b>             |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                                   | 23b. DATE <b>6-8-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b> |   |   | 23d. CITY OR TOWN <b>Brentwood</b> COUNTY <b>P.G.</b> STATE <b>Md.</b> |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>   |  |                                   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 11 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>Robert H. Shirley</b>                    |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. PAGE 6 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. PAGE 7 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

# VOCAL

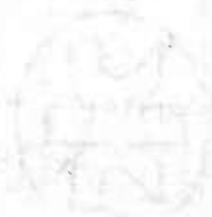


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  | REG. NO. 15618                               |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  |  |  |  |  |  |  |  | 20. DATE KNOWN OF DEATH                      |  |
| 1. DECEASED NAME (TYPE OR PRINT) <i>Roslyn N/MIN SHOLLENBERGER</i>  |  |  |  |  |  |  |  |  |  | 21. HOUR                                     |  |
| 3. SEX <i>Male</i> 4. RACE <i>White</i> 5. DATE OF BIRTH <i>12-16-13</i> 6. AGE (IN YEARS) <i>65</i> YRS. 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Penn</i> 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD.                  |  |  |  |  |  |  |  |  |  | 22. DATE PRONOUNCED DEAD <i>6-4-79</i>       |  |
| 10. CITY OR TOWN OF DEATH <i>CLINTON</i> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SOUTHERN M.D. HOSPITAL</i> 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Driver</i> 12b. KIND OF BUSINESS OR INDUSTRY <i>Taxi Co.</i>   |  |  |  |  |  |  |  |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD.</i> 13b. COUNTY <i>PRINCE GEORGE</i> 13c. CITY OR TOWN <i>DIXON HILL</i> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <i>1313 SOUTHERN AVE.</i>  |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <i>Earl E. Shollenberger</i> 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <i>Eleanor Jones</i>  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i> 16b. SOCIAL SECURITY NO. <i>577-18-2390</i> 17. INFORMANT ADDRESS <i>David R. Shollenberger Waldorf, Md.</i>   |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><i>4292 IMMEDIATE CAUSE (a) Coronary atherosclerosis</i><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><i>Diabetes mellitus</i>   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <i>August P. Rodriguez</i> M.D. <i>Deputy</i> MEDICAL EXAMINER DATE SIGNED <i>6-4-79</i>   |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <i>August P. Rodriguez</i> ADDRESS <i>5009 Rydman Ct., Comp. Springs</i>  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> 23b. DATE <i>6-7-79</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cem.</i> 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Colmar Manor, P.G. Md.</i>  |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <i>The Hunt Funeral Home Waldorf, Md.</i> 25a. DATE REC'D. BY REGISTRAR <i>JUN 11 1979</i> 25b. REGISTRAR'S SIGNATURE <i>Robert M. Brady</i>  |  |  |  |  |  |  |  |  |  |  |  |



15018



*[Faint, mostly illegible text and markings covering the page, including what appears to be a signature at the bottom left.]*

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |  |  |   |  |   |  | REG. NO. 15619  |  |
|---|--|----------------------|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Carol Ann Shrewsbury</b>   |  |                      |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 23 19 79</b>   |  | 2b. HOUR <b>a.m.</b>  |  |   |  |
| 3. SEX <b>female</b>  |  | 4. RACE <b>white</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Jan 20, 1950</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>29</b> YRS.  |  | 7. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>6 23 19 79</b>                       |  | 7b. HOUR <b>7:23 a.m.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George County</b> MD.              |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Cheverly</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Prince George Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Receptionist</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Dr Office</b>                                  |  |
| 13a. STATE <b>Md</b>  |  |                      |  |  |  | 13b. COUNTY <b>Pro Georges</b>  |  | 13c. CITY OR TOWN <b>Mt Rainier</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 13e. STREET ADDRESS <b>4003 30th Street</b>   |  |                      |  |  |  |   |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Earl Collins Sr</b>   |  |                      |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Mattie Quarles</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>219 54 5290</b>  |  | 17. INFORMANT ADDRESS <b>James L Shrewsbury Mt. Rainier, Md.</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary embolism from pelvic vein thrombosis</b><br><b>6262</b><br><del>xxxxxxxxxxxxxxxxxxxx</del><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br><b>xx following recent hysterectomy</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____      |  |                      |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                      |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION <b>6/13/79</b>   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>Intractable menorrhagia post tubal ligation stress incontinence</b>              |  |   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>H.R. Guard</b> M.D.   |  |                      |  |  |  | TITLE (SPECIFY) <b>Assistant</b> MEDICAL EXAMINER   |  | DATE SIGNED <b>6/24/79</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>  |  |                      |  |  |  | ADDRESS <b>111 Penn Street, Baltimore, MD 21201</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                      |  | 23b. DATE <b>June 27, 1979</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Brentwood Pro Georges Md.</b>       |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons P A</b>  |  |                      |  |  |  | ADDRESS <b>Hyattsville, Md</b>  |  | 25a. DATE RECEIVED BY REGISTRAR <b>JUN 28 1979</b>                                |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  | REG. NO. 15620   |  |
|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Catherine A. Sicoronsa</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>6</b> DAY <b>18</b> YEAR <b>79</b>                                   |  | 2b. HOUR <b>1:52</b> M  |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>2</b> YEAR <b>85</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93 YR</b>  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ireland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges Co.</b> MD.                              |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Clinton</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Clinton Convalescent Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  | 13e. STREET ADDRESS<br><b>6706 Genova Lane</b>  |  |  |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Pr. Georges</b>   |  | 13c. CITY OR TOWN<br><b>Camp Springs</b>  |  |  |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Edward</b> MIDDLE <b>McGreevy</b> LAST <b></b>   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Julia</b> MIDDLE <b></b> LAST <b>Farrell</b>                  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>138-20-7746</b>  |  | 17. INFORMANT<br><b>Daughter Alexandria, Va. 22304</b><br><b>Barbara Walsh, 205 Youkum Parkway</b> |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Congestive Heart failure</b><br><b>4140</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DOE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerosis of the Heart</b><br>DOE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |   |  |   |  |  |  |   |  | APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                     |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/9</b> 19 <b>79</b> to <b>6/18</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/18</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>R. M. ...</b>   |  |   |  |   |  | DEGREE<br><b></b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6/18/79</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. M. ...</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>4235 26 Ave NW 2013</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>6-20-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Catherine's Cem.</b>   |  |  |  | 23d. LOCATION<br>CITY OR TOWN <b>Monmouth</b> COUNTY <b></b> STATE <b></b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Robt E Wilhelm</b> ADDRESS <b>4308 Suitland Rd., Suitland, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 22 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |   |  |  |  |

MEDICAL CERTIFICATION

99

1204 BP

USCGC R/V

WATERWAY



1/15/74

1/15/74



OFFICE OF THE DISTRICT ATTORNEY  
STATE OF CALIFORNIA





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15621

FOR  
STATE  
REGISTRAR

|  |  |  |   |  |  |   |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Bertha</b>   |  |  | FIRST MIDDLE LAST <b>SIMMS</b>  |  |  | 2a DATE OF DEATH MONTH DAY YEAR <b>June 17, 1979</b>  |  |  | 2b HOUR P M <b>11:45</b>  |  |  |
| 3 SEX <b>Female</b>  |  |  | 4 RACE <b>Black</b>   |  |  | 5 DATE OF BIRTH MONTH DAY YEAR <b>April 1899</b>  |  |  | 6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.   |  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Spartanburg, S.C.</b>  |  |  | 7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges' County, MD.</b>  |  |  |
| 10 CITY OR TOWN OF DEATH <b>Glenn Dale</b>   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Glenn Dale Hospital</b> |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>  |  |  | 12b KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>D.C.</b>  |  |  | 13b COUNTY <b>Washington</b>  |  |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 13e STREET ADDRESS <b>Unknown</b>   |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST <b>Andy Maxwell</b>   |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Cannady</b>  |  |  | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  |  | 16b SOCIAL SECURITY NO.   |  |  |
| 17 INFORMANT ADDRESS <b>Mrs. Artelia Whiteside Landrum, S.C. Route 1</b>   |  |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: <b>Pulmonary Embolism</b>     |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>  |  |  |   |  |  |
| IMMEDIATE CAUSE (a) <b>7159</b>  |  |  | DUE TO, OR AS A CONSEQUENCE OF (b) <b>Osteoarthritis</b>  |  |  | years   |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |   |  |  |   |  |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes mellitus; chronic brain syndrome with psychotic paranoid reaction.</b>   |  |  |   |  |  |   |  |  |   |  |  |
| 19a DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |   |  |  |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |
| 22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 24</b> , 19 <b>71</b> , to <b>June 17</b> , 19 <b>79</b> , that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> (we) lost the deceased alive on <b>above</b> , <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (we) did not view the body after death. |  |  |   |  |  |   |  |  |   |  |  |
| 22b SIGNATURE <b>James W. Wills, M.D.</b>  |  |  | DEGREE <b>M.D.</b>  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                         |  |  | 22c DATE SIGNED <b>June 17, 1979</b>  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>James W. Wills, M.D.</b>   |  |  | 22e ADDRESS <b>Glenn Dale Hospital, Glenn Dale, Maryland 20769</b>  |  |  |   |  |  |   |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |  | 23b DATE <b>6-25-79</b>   |  |  | 23c NAME OF CEMETERY OR CREMATORY <b>Union Grove Cem</b>  |  |  | 23d LOCATION CITY OR TOWN COUNTY STATE <b>Landrum, S.C.</b>   |  |  |
| 24 FUNERAL DIRECTOR NAME <b>James A. Morton &amp; Sons</b>   |  |  | ADDRESS <b>1701 Landon St. Balt. Md.</b>  |  |  | 25 DATE REC'D. BY REGISTRAR <b>JUN 25 1979</b>  |  |  | 25b REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>   |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by telephone.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|---|--|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 7 9 1 5 6 2 2   |  |  |  | REG. NO.  |  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST<br>GENEVA   |  | MIDDLE<br>P.   |  | LAST<br>SINGLETON   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06-03-79  |  | 2b. HOUR<br>4 P M                            |  |
| 3 SEX<br>FEMALE  |  | 4 RACE<br>BLACK   |  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>10/7/96   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.   |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS   |  | 8 IF UNDER 24 HRS<br>HOURS MIN.              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>S. C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGE'S MD.  |  |  |  |  |  |
| 10 CITY OR TOWN OF DEATH<br>CHEVERLY   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PRINCE GEORGE'S GENERAL HOSPITAL |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>TEACHER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>EDUCATION   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE<br>MD.   |  | 13b. COUNTY<br>P.G.  |  | 13c. CITY OR TOWN<br>DIST. HEIGHT   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS<br>1307 CENTAUR DRIVE    |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>JOHN PINCKNEY   |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>RACHAEL GENERETTE  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>249 60 7248  |  | 17 INFORMANT<br>WILLIAM C. SINGLETON-SAME AS DECEDENT  |  |   |  | ADDRESS  |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple (stroke) C.V.A.<br>436-<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) Cardio. pulm. arrest.<br>DUE TO, OR AS A CONSEQUENCE OF (c) — |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/22/79, 19 79, to 6/3/79, 19 79, that (I) (we) last saw the deceased alive on 6/3/79, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>M.P. Shah  |  | DEGREE M.D.<br>Gor Dr. Chandan.   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>6/4/79   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MAHESH P. SHAH.   |  |   |  | 22e. ADDRESS<br>P.O. C.H. & M.C. Cheverly, MD. 20785.  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>6/9/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>RESERVE BLOW CEM   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>CHARLESTON SOUTH CAROLINA   |  |  |  |  |  |
| 24 FUNERAL DIRECTOR<br>NAME<br>2661 4000 JONES RD. S.E. WASHINGTON D.C. 20020  |  |   |  | 25a. DATE RECEIVED BY REGISTRAR<br>JUN 7 1979  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |

1 2 3 4 5 6 7 8 9 10 11 12



1 2 3 4 5 6 7 8 9 10 11 12



1 2 3 4 5 6 7 8 9 10 11 12

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |   | 9 1 5 6 2 3  |  |  |
|---|--|---|--|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |   |  |  |   | REG. NO.   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><div style="display: flex; justify-content: space-between;"><div>FIRST<br/><b>Celina</b></div><div>MIDDLE<br/></div><div>LAST<br/><b>Slattery</b></div></div>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><div style="display: flex; justify-content: space-around;"><div><b>June</b></div><div><b>24</b></div><div><b>1979</b></div></div> |   | 2b. HOUR<br><b>8:00 p.m.</b>   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Mar. 1 1895</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>84 YRS.</b>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Ireland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>              |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George MD</b>  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Hyattsville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Sacred Heart Nursing Home</b> |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker and PBX operator</b>                                      |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY<br><b>Montgomery</b>   |   | 13c. CITY OR TOWN<br><b>Silver Spring</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Patrick Gannon</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Gehring</b>   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>579-28-1763</b>  |  | 17. INTERPRETER'S NAME AND ADDRESS<br><b>MARGARET CARROLL, SAME AS 13 DAUGHTER</b><br><del>Bureau of Vital Records, Hyattsville, Md. 20782</del>                         |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>4392</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>PARKINSONISM</b>   |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |  |
| 22a. I certify that (I) [this hospital] attended the deceased from <b>April 25 1979</b> , to <b>June 24 1979</b> , that (I) <del>was</del> lost saw the deceased alive on <b>June 22 1979</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) <del>not</del> see the body after death.  |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Bernard A. FitzGerald MD</b>   |  |   |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |
| 22c. DATE SIGNED<br><b>6-24-79</b>  |  |   |  |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BERNARD A. FITZGERALD</b>   |  |   |  | 22e. ADDRESS<br><b>217 UNIVERSITY BLVD., SILVER SPRING, MD 20901</b>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>6/27/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON NATIONAL</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ARLINGTON VIRGINIA</b>  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b><br><b>500 UNIV. BLVD. W. SILVER SPRING, MD. 20901</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 29 1979</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Hickory McBrady</b>   |  |  |

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| Serial     | Birth      | Death      | Age | Sex | Color | Height | Weight | Build   | Complexion | Occupation | Education   | Religion | Marital Status | Place of Birth | Place of Death | Cause of Death | Time of Death | Time of Burial | Place of Burial |
|------------|------------|------------|-----|-----|-------|--------|--------|---------|------------|------------|-------------|----------|----------------|----------------|----------------|----------------|---------------|----------------|-----------------|
| 100-100000 | 1900-01-01 | 1900-01-01 | 00  | M   | White | 5'10"  | 150    | Medium  | Fair       | Student    | High School | Catholic | Single         | New York, NY   | New York, NY   | Heart Disease  | 1900-01-01    | 1900-01-01     | New York, NY    |
| 100-100001 | 1900-01-02 | 1900-01-02 | 00  | F   | White | 5'0"   | 100    | Slender | Fair       | Homemaker  | High School | Catholic | Single         | New York, NY   | New York, NY   | Heart Disease  | 1900-01-02    | 1900-01-02     | New York, NY    |
| 100-100002 | 1900-01-03 | 1900-01-03 | 00  | M   | White | 6'0"   | 180    | Medium  | Fair       | Student    | High School | Catholic | Single         | New York, NY   | New York, NY   | Heart Disease  | 1900-01-03    | 1900-01-03     | New York, NY    |
| 100-100003 | 1900-01-04 | 1900-01-04 | 00  | F   | White | 5'5"   | 120    | Medium  | Fair       | Homemaker  | High School | Catholic | Single         | New York, NY   | New York, NY   | Heart Disease  | 1900-01-04    | 1900-01-04     | New York, NY    |
| 100-100004 | 1900-01-05 | 1900-01-05 | 00  | M   | White | 5'8"   | 140    | Medium  | Fair       | Student    | High School | Catholic | Single         | New York, NY   | New York, NY   | Heart Disease  | 1900-01-05    | 1900-01-05     | New York, NY    |
| 100-100005 | 1900-01-06 | 1900-01-06 | 00  | F   | White | 5'2"   | 110    | Slender | Fair       | Homemaker  | High School | Catholic | Single         | New York, NY   | New York, NY   | Heart Disease  | 1900-01-06    | 1900-01-06     | New York, NY    |
| 100-100006 | 1900-01-07 | 1900-01-07 | 00  | M   | White | 6'2"   | 200    | Medium  | Fair       | Student    | High School | Catholic | Single         | New York, NY   | New York, NY   | Heart Disease  | 1900-01-07    | 1900-01-07     | New York, NY    |
| 100-100007 | 1900-01-08 | 1900-01-08 | 00  | F   | White | 5'3"   | 115    | Medium  | Fair       | Homemaker  | High School | Catholic | Single         | New York, NY   | New York, NY   | Heart Disease  | 1900-01-08    | 1900-01-08     | New York, NY    |
| 100-100008 | 1900-01-09 | 1900-01-09 | 00  | M   | White | 5'7"   | 135    | Medium  | Fair       | Student    | High School | Catholic | Single         | New York, NY   | New York, NY   | Heart Disease  | 1900-01-09    | 1900-01-09     | New York, NY    |
| 100-100009 | 1900-01-10 | 1900-01-10 | 00  | F   | White | 5'1"   | 105    | Slender | Fair       | Homemaker  | High School | Catholic | Single         | New York, NY   | New York, NY   | Heart Disease  | 1900-01-10    | 1900-01-10     | New York, NY    |

Serial 100-100000  
Birth 1900-01-01  
Death 1900-01-01  
Age 00  
Sex M  
Color White  
Height 5'10"  
Weight 150  
Build Medium  
Complexion Fair  
Occupation Student  
Education High School  
Religion Catholic  
Marital Status Single  
Place of Birth New York, NY  
Place of Death New York, NY  
Cause of Death Heart Disease  
Time of Death 1900-01-01  
Time of Burial 1900-01-01  
Place of Burial New York, NY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M7/77  
(VR A15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |  |  |   |   |  |  |  |   |  |   |  |  |
|---|--|--|---|---|--|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Theodore Joseph SLEEMAN</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>June 7, 1979</b> |   |  | 2b. HOUR<br><b>12:05 AM</b>  |  |   |  |   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 29, 1893</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.  |  | 7. UNDER 1 YEAR<br>MONTHS DAYS<br><b>— —</b>  |  | 7. UNDER 24 HRS<br>HOURS MIN.<br><b>— —</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Limasol, Cyprus</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S. of Am.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges</b> MD.                                      |  |   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Temple Hills</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Verdeja's Care 5301 Donna Lane, Temple Hills</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Grocery Clerk</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Food</b>  |  |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>D.C.</b>   |  |  |   | 13b. COUNTY<br><b>—</b>   |  | 13c. CITY OR TOWN<br><b>Washington</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1415 19th St. S.E.</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph — Sleeman</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary ?</b>  |  |  |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W.I 579-012561</b>  |  | 17. INFORMANT <b>Daughter</b> ADDRESS<br><b>Shirley Neri 5705 Nevada Street Berwyn Hts., Md. 20740</b> |  |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b><br>1629 } DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Metastases</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 1/2 years</b> |  |  |   |   |  |  |  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Arteriosclerotic Heart Disease (2 Preceder for 9 years) 20 yrs</b>  |  |  |   |   |  |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>— P.M. — 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>—</b>             |  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>— — — —</b>                                    |  |   |  |   |  |  |
| 22a. I certify that (I) <del>the hospital</del> attended the deceased from <b>April 24, 1979</b> to <b>June 7, 1979</b> , that (I) <del>was</del> lost saw the deceased alive on <b>May 31, 1979</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>have</del> did not view the body after death.   |  |  |   |   |  |  |  |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Walcutt W. Gibson M.D.</b>   |  |  |   |   |  |  |  | DEGREE<br><b>—</b>  |  | 22c. DATE SIGNED<br><b>June 7, 1979</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Walcutt W. Gibson, M.D.</b>   |  |  |   |   |  |  |  | 22e. ADDRESS<br><b>4300 St. Bernzbas Road, Marlow Heights, Md. 20031</b>                        |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  |   | 23b. DATE<br><b>6-9-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resurrection Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Clinton, P.G., Maryland</b>                    |  |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Robt E Wilhelm</b>  |  |  |   | ADDRESS<br><b>4308 Suitland Rd., Suitland, Md.</b>  |  | 25a. DATE OF REGISTRATION<br><b>JUN 11 1979</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>—</b>  |  |   |  |  |

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RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

MEMORANDUM FOR THE DIRECTOR  
SUBJECT: [Illegible]  
DATE: [Illegible]  
FROM: [Illegible]  
TO: [Illegible]  
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report.]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                      |  |  |   |  |  |  |   |                    | REG. NO. 15625  |  |
|---|----------------------|--|--|---|--|--|--|---|--------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Aubrey Boyd SMITH</b>   |                      |  |  |   |  |  |  |   |                    | 2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6-28 1979</b> |  |
| 3. SEX <b>Male</b>  | 4. RACE <b>White</b> | 5. DATE OF BIRTH (MONTH DAY YEAR) <b>DEC 6-13 65</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>65 YRS.</b>                                | IF UNDER 1 YR. MONTHS DAYS   | IF UNDER 24 HRS. HOURS MIN.  | 2c. DATE PRONOUNCED DEAD <b>6-28 1979</b>                  |   | 2b. HOUR <b>11</b> |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince Georges</b> |   | MD.                |   |  |
| 10. CITY OR TOWN OF DEATH <b>Laurel</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>15709 Ashland Dr.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NSA</b>                     |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>                      |                    |   |  |
| 13a. STATE <b>Maryland</b>  |                      | 13b. COUNTY <b>P.G. Co.</b>  |  | 13c. CITY OR TOWN <b>Laurel</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS <b>15709 Ashland Dr.</b>                            |                    |   |  |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Ruscoe C. Smith</b>  |                      |  |  |   | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Hettie Agee</b>  |  |  |   |                    |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>   |                      | (IF YES, GIVE WAR OR DATES) <b>WWII</b>  |  | 16b. SOCIAL SECURITY NO. <b>411-42-6636</b>                                   |  | 17. INFORMANT ADDRESS <b>Jessie B. Smith same as #13</b>                                     |  |   |                    |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>410-<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Coronary atherosclerosis with abdominal aortic debranch graft</b><br>(c) _____<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). _____ |                      |  |  |   |  |  |  |   |                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a. DATE OF OPERATION  |                      |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                    |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                      | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |   |                    |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |  |  |   |                    |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .   |                      |  |  |   |  |  |  |   |                    |   |  |
| ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b>  |                      | TITLE (SPECIFY) <b>Deputy</b>  |  |   |  | DATE SIGNED <b>6-28-79</b>   |  |   |                    |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez, M.D.</b>   |                      | ADDRESS <b>5009 Rayburn Ct., Camp Springs, Md. 20031</b>   |  |   |  |  |  |   |                    |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |                      | 23b. DATE <b>7/2/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cam</b>              |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Arlington, Va</b> |                    |   |  |
| 24. FUNERAL DIRECTOR <b>FLECK LAUREL FUNERAL HOME, INC.</b>   |                      |  |  | 25. DATE REC'D BY REGISTRAR <b>JUN 29 1979</b>                                |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Fitzpatrick</b>                           |                    |   |  |
| ADDRESS <b>7601 Sandy Spring Rd. Laurel, Md. 20810</b>  |                      |  |  |   |  |  |  |   |                    |   |  |

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of Southern California  
Los Angeles, California  
California State Board of Education  
Sacramento, California

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Page 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15626

FOR  
STATE  
REGISTRAR

|   |  |   |  |  |  |  |   |  |  |
|---|--|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Nancy R. Somerville  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>June 15 1979                    |  |  | 2b. HOUR<br>9:00 a.m.  |   |  |  |
| 3 SEX<br>F  | 4 RACE<br>Blk  | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 24, 1912  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>66 YRS                              |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                 |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George's MD.            |  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Riverdale  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Eugene Leland Memorial Hospital |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>House Wife |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.   |  |   | 13b. COUNTY<br>P. G.   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry Robinson  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Ida Palmer            |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>Not Stated  |  | 17. INFORMANT<br>ADDRESS<br>Brownie Somerville 5902 31st. Ave. |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Ventricular arrhythmia</i><br><i>4140</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Atherosclerosis, hypertensive heart disease</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>minutes</i><br><i>years</i> |  |   |  |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>Massive Right cerebral infarction, Hypertension, diabetes mellitus</i>  |  |   |  |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |
| 22a. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>5/17</i> , 19 <i>79</i> , to <i>6/15</i> , 19 <i>79</i> , that (I) ( <del>was</del> ) last saw the deceased alive on <i>6/14</i> , 19 <i>79</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) (did) ( <del>not</del> ) view the body after death.   |  |   |  |  |  |  |   |  |  |
| 22b. SIGNATURE<br><i>Byrl O. Johnson</i>  |  |   | DEGREE<br><i>MD</i>  |  |  | 22c. DATE SIGNED<br><i>6/15/79</i>   |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Byrl O. Johnson, M. D.   |  |   | 22e. ADDRESS<br>4404 Queensbury Road, Riverdale, Md.                   |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>June 19, 1979   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oke Grove Cem            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Littleton N.C.                                    |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Watson F. H. 3435 14th St., N. W.   |  |   | 25a. DATE RECD. BY REGISTRAR<br>JUN 23 1979                            |  |  | 25b. REGISTRAR'S SIGNATURE   |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |   |   |  |  |
|---|--|--|--|---|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   | REG. NO. 9 15627   |  |   |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>IRENE M. SPEAKES</b>   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>06-26-79</b>                |  |   | 2b. HOUR<br><b>2:49AM</b>   |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>12-16-1896</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS<br><b>82 YRS.</b>  |   | IF UNDER 1 YEAR IF UNDER 24 HRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>PRINCE GEORGES MD.</b>  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CHEVERLY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>PRINCE GEORGES GENERAL HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>   |  |  |  |   | 13b. COUNTY<br><b>Pr. Geo.</b>                                     |  | 13c. CITY OR TOWN<br><b>Mt. Rainier</b> |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Thomas Mock</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lena Cockrell</b> |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>577-03-7538</b>   |  | 17. INFORMANT<br><b>Alfred W. Speakes</b>   |  | ADDRESS<br><b>4305-55th Ave. Bladensburg, Md.</b>  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-vascular artery arrest</b><br><b>4/4/1</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CHD, old MI</b><br>(c) <b>left ventricular aneurysm</b> |  |  |  |   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6-17-79</b> to <b>6-26-79</b> , that (I) (we) last saw the deceased alive on <b>6-26-79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                          |  |  |  |   |  |  |   |   |  |  |
| 22b. SIGNATURE<br><b>H. A. Molavi</b> DEGREE <b>MD</b>  |  |  |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>6.26.79</b>  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>H. A. Molavi</b>  |  |  |  | 22e. ADDRESS<br><b>6005 Landover Rd Cheverly, Md</b>  |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>6-29-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Brentwood Pr. Geo. Md.</b>   |   |   |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Nalley's F.H. Inc.</b>  |  |  |  | ADDRESS<br><b>Mt. Rainier, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 2 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>History McCreedy</b>   |  |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1- STATE REGISTRAR<br><b>RICHARD M. Spencer</b>   |  | REG. NO. <b>15628</b>   |  | 2a. DATE KNOWN OF DEATH<br><b>June 6-15 1979</b>  |  | 2b. HOUR<br><b>6:45 P</b>  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Richard M. SPENCER</b>   |  | LAST<br><b>SPENCER</b>  |  | 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Black</b>  |  | 5. DATE OF BIRTH<br><b>March 3-24-34</b>                                       |  |
| 6. AGE (IN YEARS)<br><b>45</b>  |  | IF UNDER 1 YR.<br>MONTHS DAYS MIN.  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7c. DATE PRONOUNCED DEAD<br><b>June 6-15 1979</b>                                |  | 7d. HOUR<br><b>6:45 P</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Brima Geags</b>                       |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Chesverly</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Prince George General Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Schools</b>                              |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. CITY OR TOWN<br><b>Prince George</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS<br><b>2010 Tiber Drive</b>                                   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Hubert Spencer</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Curley Poindexter</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>1957-1959 223 36 1027</b>                         |  | 17. INFORMANT ADDRESS<br><b>Lois Spencer-wife-2010 Tiber Drive, HtsMD Dist</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE <b>Hypertensive cardiovascular disease</b><br><b>4029</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion |  |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Augusta P. Rodriguez</b>   |  | TIME (SPECIFY)<br><b>10 July</b>  |  | MEDICAL EXAMINER<br><b>Augusta P. Rodriguez</b>   |  | DATE SIGNED<br><b>6-15-79</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>Augusta P. Rodriguez</b>  |  | ADDRESS<br><b>5009 Rayburn Court Camp Springs</b>   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>JUNE 6/21/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Colmar Manor, P.G. Maryland</b> |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>ALEXANDER S. POPE</b>   |  | ADDRESS<br><b>2617 Pennsylvania Ave., S.E.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 22 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Barney McCreedy</b>                             |  |  |  |





CHARLES M. Spencer

JUNE

Marion

United States

Virginia

Schools Teacher

James George Connell Hospital

Gravelly

2010 Elmer Drive

James George Connell Hospital

Maryland

Beltsville

Curley

Spencer

Hubert

late Spencer wife - 2010 Elmer Drive, H.D.

2010 Elmer Drive

1951-1952

yes

JUNE

James Moore, P.O. Maryland

W.C. Lincoln Building

burial

Washington, D.C.

Washington, D.C. 20001

Released by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                              |  | 2a. DATE OF DEATH   |  |  |  | 2b. HOUR  |  |   |  |   |  |
|--|--|------------------------------|--|---|--|--|--|---|--|---|--|---|--|
| FIRST  |  | MIDDLE                       |  | LAST  |  | MONTH  |  | DAY   |  | YEAR  |  | HOUR  |  |
| JESSE WILLARD STACK  |  |                              |  | JUNE  |  | 19   |  | 1979  |  | 11:40A  |  | M   |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH  |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS                                       |  |
| Male   |  | Caucasian                    |  | Dec. 9 19 1918  |  |  |  | 60  |  | MONTHS  |  | DAYS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                     |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George's MD.         |  |   |  |   |  |
| Virginia   |  | U.S.A.                       |  |   |  |  |  |   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  |                              |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY                                     |  |   |  |
| Lanham   |  |                              |  | Doctors' Hospital of Pr. Geo. Co.   |  |  |  | Salesman -  |  | Automobile  |  |   |  |
| 13a. STATE   |  |                              |  | 13b. CITY OR TOWN   |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS   |  |   |  |   |  |
| Md.  |  | Pr. Geo.                     |  | Greenbelt   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 8561 - Greenbelt Rd.  |  |   |  |   |  |
| 14. FATHER'S NAME  |  |                              |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |   |  |   |  |   |  |
| FIRST  |  | MIDDLE                       |  | LAST  |  | FIRST  |  | MIDDLE  |  | LAST  |  |   |  |
| S.   |  | P.                           |  | Stack   |  | Emma   |  |   |  |   |  | Morris  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |                              |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  |   |  |   |  |   |  |
| Yes  |  |                              |  | WWII  |  | 240-18-4088 Mary M. Stack - above address (Wife)                               |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                              |  |   |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 Hrs |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |                              |  |   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?        |  |   |  |
|  |  |                              |  |   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>              |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                              |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>4-5</u> 19 <u>79</u> , to <u>6-19</u> 19 <u>79</u> , that (I) (the) last saw the deceased alive on <u>6-12</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) view the body after death.                                |  |                              |  | 22b. SIGNATURE<br><u>Lawrence Satin MD</u> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br>6-20-79   |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lawrence Satin, M.D.  |  |                              |  | 22e. ADDRESS<br>5711 Sarvis Ave., Riverdale, Md. 20840  |  |  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  |                              |  | 23b. DATE<br>6/25/1979  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Salisbury Nat. Cem.                      |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Salisbury Rowan N. Car. |  |   |  |
| 24. FUNERAL DIRECTOR'S NAME<br>Valley's F.H. Inc.  |  |                              |  | ADDRESS<br>Mt. Rainier, Md.   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 25 1979                        |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                      |  |   |  |

1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |                               |  |   |  |
|---|--|---|--|--|--|--|-------------------------------|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  |  |  |                               |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>DOUGLAS P. STRANGE   |  |   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06-19-79                |  |                               | 2b. HOUR<br>10.P. M.   |   |  |
| 3 SEX<br>Male   |  | 4 RACE<br>Black   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Aug. 21, 1941  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>37 YRS   |                               | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGE'S COUNTY MD.                   |                               |  |   |  |
| 10 CITY OR TOWN OF DEATH<br>CHEVERLY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PRINCE GEORGE'S GENERAL HOSPITAL |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Trk. Driver      |                               | 12b. KIND OF BUSINESS OR INDUSTRY<br>Const.  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Md.  |  |   |  |  | 13b. COUNTY<br>Prince Geo.                                     |  | 13c. CITY OR TOWN<br>Cheverly |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert Strange  |  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Elsie Wilkins |  |                               |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br>225-52-3827   |  | 17. INFORMANT ADDRESS<br>Vernal Strange, 5501 Landover Rd. Cheverly, Md.   |  |  |                               |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CVA</u><br><u>431-</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Intracerebral hemorrhage</u><br>(c) <u>Hypertension</u>     |  |   |  |  |  |  |                               |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Cardiorespiratory Arrest</u>  |  |   |  |  |  |  |                               |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |                               |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                               |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |                               |  |   |  |
| 22b. SIGNATURE<br><u>J. Colella</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |                               | 22c. DATE SIGNED<br>6/20/79  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. Colella   |  |   |  | 22e. ADDRESS<br>Prince Geo. Gen. Hospital  |  |  |                               |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>6/23/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Family   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>S. Boston, Va.                         |                               |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Nelson E. Grunberg  |  |   |  | 24b. ADDRESS<br>814 Franklin St. Alex. VA 22314  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 27 1979   |                               | 25b. REGISTRAR'S SIGNATURE<br>H. H. H. H.  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |   |  |
|---|--|---|--|---|--|---|--|---|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | 7 15631<br>REG. NO.  |   |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Helen Marie SUBE  |  |   |  |   | 2a. DATE OF DEATH<br>June 28, 1979   |   |  | 2b. HOUR<br>10:20p.m.                             |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>July 15, 1907   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.      |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Indiana  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George's County MD.            |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Lanham   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Doctors Hosp. of P.G. County |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Service Rep. |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Bell Teleph. |   |  |
| 13a. STATE<br>Md.   |  |   |  |   | 13b. COUNTY<br>P.G.  |   | 13c. CITY OR TOWN<br>Bowie   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>Otto Sube  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>Christine Petersen                                       |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>320-10-2701   |  | 17. INFORMANT ADDRESS<br>Paul Sube same as # 13   |  |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Renal Insufficiency</u><br>1889<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA OF THE BLOOD</u><br>3-4 mos |  |   |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3-4 mos   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>ASHD - CVA'S - COPE</u>   |  |   |  |   |  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>MAY 28</u> , 19 <u>79</u> , to <u>JUNE 28</u> , 19 <u>79</u> , that (1) (we) lost saw the deceased alive on <u>JUNE 28</u> , 19 <u>79</u> , and that in my (1) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.                       |  |   |  |   |  |   |  |   |   |  |
| 22b. SIGNATURE<br>Charles F. Colao MD   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>6/29/79                       |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Charles F. Colao MD  |  |   |  | 22e. ADDRESS<br>3716 Riviera St. - MARLOW Hgts  |  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation  |  | 23b. DATE<br>6-30-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Metropolitan Crem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Alexandria Virginia             |  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Huntt Funeral Home  |  |   |  | ADDRESS<br>Waldorf, Maryland  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUL 5 1979                                   |  |   |   |  |

MEDICAL CERTIFICATION

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TO THE SECRETARY  
OF THE ARMY  
WASHINGTON, D.C.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  | 79 15632            |     |   |          |
|--|--|--|--|--|--|---|--|--|--|---------------------|-----|---|----------|
| 1. FOR STATE REGISTRAR   |  | REG. NO.   |  |  |  |   |  |  |  |                     |     |   |          |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH                            |  | MONTH               | DAY | YEAR  | 2b. HOUR |
| ARLENE L.  |  | Sutphin  |  |  |  |   |  | 6/19/79                                      |  |                     |     |   | 1:12 PM  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                              |  | IF UNDER 24 HRS     |     |   |          |
| FEMALE   |  | WHITE  |  | NOV 20, 1937   |  | 41 YRS.   |  | MONTHS                                       |  | DAYS                |     | HOURS MIN.  |          |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                     |     |   |          |
| MARYLAND   |  | U.S.A.   |  |  |  | PRINCE GEORGES MD.  |  |  |  |                     |     |   |          |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                     |     |   |          |
| LANHAM   |  | DOCTORS' HOSPITAL  |  | NURSES AID   |  | GREENBELT CONVALESCENT CENTER                                       |  |  |  |                     |     |   |          |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?                     |  | 13e. STREET ADDRESS |     |   |          |
| MARYLAND   |  | PRI. GEO   |  | GREENBELT  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 207 LAKESIDE DRIVE                           |  |                     |     |   |          |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |                     |     |   |          |
| JOHN T. BLOCHER  |  | AGNES HOTT   |  |  |  |   |  |  |  |                     |     |   |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |                     |     |   |          |
| NO   |  | 579-46-0839  |  | BENNY D. SUTPHIN   |  | SAME AS 13 HUSBAND  |  |  |  |                     |     |   |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  | PART I. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                     |     |   |          |
| 430-   |  | Subarachnoid Hemorrhage  |  |  |  |   |  | 2 1/2 wks                                    |  |                     |     |   |          |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | (b)  |  | Ruptured Intracranial Aneurysm   |  |   |  | 2 1/2 wks                                    |  |                     |     |   |          |
|  |  | (c)  |  |  |  |   |  |  |  |                     |     |   |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                 |  |  |  |  |  |   |  |  |  |                     |     |   |          |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |                     |     |   |          |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |                     |     |   |          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED   |  | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |  |  |                     |     |   |          |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |                     |     |   |          |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY   |  | 21f. LOCATION  |  |   |  |  |  |                     |     |   |          |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | STREET   |  | CITY OR TOWN  |  | COUNTY                                       |  | STATE               |     |   |          |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  | MAY 31, 19 79  |  | to   |  | 6/19/ 19 79   |  | that (I) (we) last saw the deceased alive on |  | 6/12/79             |     | 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |          |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |  |  |                     |     |   |          |
| Robert Gerwin  |  | MD   |  | 6/19/79  |  |   |  |  |  |                     |     |   |          |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |  |  |   |  |  |  |                     |     |   |          |
| Robert Gerwin MD   |  | 9811 MAHAN Drive, Laurel Md 20811  |  |  |  |   |  |  |  |                     |     |   |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | CITY OR TOWN                                 |  | COUNTY              |     | STATE   |          |
| BURIAL   |  | 6/22/79  |  | EMANUEL METH. CH. CEMETERY   |  | FROSTBURG   |  |  |  |                     |     | MARYLAND  |          |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |                     |     |   |          |
| FRANCIS J. COLLINS   |  | JUN 25 1979  |  | F. J. COLLINS  |  |   |  |  |  |                     |     |   |          |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  |  |  |  |  |   |  |  |  |                     |     |   |          |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |   |   |   |   |
|--|--|---|--|---|---|---|---|---|---|
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO. 7 9 1 5 6 3 3  |   |   |   |   |
| 1. DECEASED NAME (TYPE OR PRINT)<br><b>Lawrence D. Suvall</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br><b>June 12, 1979 10:30PM</b>   |   |   |   |   |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Jan. 3, 1919</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>60 60 YRS.</b>                       |   | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.             |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New York</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George County MD.</b>                           |   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Laurel</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Greater Laurel Beltsville Hospital</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Dept. of Defence U.S.Gov.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY               |   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>P.G. Co.</b>  |  | 13c. CITY OR TOWN<br><b>Laurel</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |   | 13e. STREET ADDRESS<br><b>7016 Redmiles Rd.</b> |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Nathan Suvall</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Lillian Rothstein</b>  |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>WWII</b>   |  | 17. INFORMANT<br><b>Ellen Suvall</b>  |   | ADDRESS<br><b>same as #13</b>   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>hypoperfusion</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ruptured abd. aneurysm</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) <b>None</b> |  |   |  |   |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 min.</b> |
| 19a. DATE OF OPERATION<br><b>6/11/79</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ruptured abd. aneurysm</b>   |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>P.M. 19  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>6/11</b> , 19 <b>79</b> , to <b>6/13</b> , 19 <b>79</b> , that (I) (we) lost saw the deceased alive on <b>6/13</b> , 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |   |   |   |
| 22b. SIGNATURE<br><b>W. Stuart Battle M.D.</b>   |  |   |  |   | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>6/13/79</b>  |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. Stuart Battle M.D.</b>  |  |   |  |   | 22e. ADDRESS<br><b>321 Prince George ST Laurel Md 20810</b>   |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>6/15/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lincoln Park Cem.</b>  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Warwick, Kent, Rhode Isl</b>                        |   |   |   |
| 24. FUNERAL DIRECTOR<br><b>FLECK LAUREL FUNERAL HOME, INC.</b>   |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 15 1979</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |   |
| 26. FUNERAL HOME ADDRESS<br><b>7601 Sandy Spring Rd. Laurel, Md. 20810</b>   |  |   |  |   |   |   |   |   |   |

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FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 9 1 5 6 3 4

|   |  |   |   |  |   |   |  |  |  |
|---|--|---|---|--|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>HALLIE BELL THOMPSON</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>6 27 79</b>                 |  |   | 2b. HOUR<br><b>12-05<sup>P</sup></b>  |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10 11 1903</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Pr. Geo.</b>   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pr. Geo. Gen. Hosp.</b> |   |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>                      |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>M.D.</b>   |  | 13b. COUNTY<br><b>P.G.</b>  |   | 13c. CITY OR TOWN<br><b>College Park</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4823 - OSAGA ST, Osage</b>               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Boyd Robinette</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Julia Sarvers</b> |  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO<br>(IF YES, GIVE WAR OR DATES)<br><b>-</b>  |   | 17. INFORMANT ADDRESS<br><b>William R. Thompson Same as above</b>  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis.</b><br>2500<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Coronary Artery Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes mellitus.</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |   |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>19 74</b> to <b>6-22-</b> 19 <b>79</b> , that (I) (we) last saw the deceased alive on <b>6/22/</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |   |   |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Abdul Nayeem</b>   |  |   |   | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   |  | 22c. DATE SIGNED<br><b>6/28/79</b>                                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ABDUL NAYEEM.</b>   |  |   |   | 22e. ADDRESS<br><b>11403. HOWARD</b>   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>6-30-79</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland Pr. Geo. Md.</b>                      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Nalley's F.H. Inc. Mt. Rainier, Md.</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRY<br><b>JUL 2 1979</b>  |   |   |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | REG. NO. 15635                               |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1- FOR STATE REGISTRAR  |  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Elmer E. TICE</i>   |   |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <i>6-1-1979</i>                                     |   | 7b. HOUR   |  |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>White</i>                    |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>August 28/10 68</i> YRS.      |  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <i>68</i> YRS.  |  | IF UNDER 1 YR. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Pennsylvania</i>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Prince Georges</i>                       |  | 7d. HOUR                                     |  |
| 10. CITY OR TOWN OF DEATH<br><i>Cheverly</i>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Prince George's General Hosp.</i> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Carpenter - Ret.</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Construction</i> |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  |  |  |   |  |  |  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Prince George</i>        |  | 13c. CITY OR TOWN<br><i>Oxon Hill</i>                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><i>411 Carey Brook Lane</i>                                  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>George Tice</i>  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Adda Connolly</i>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><i>Yes</i>   |  | (IF YES, GIVE WAR OR DATES)<br><i>WWII</i> |  | 16b. SOCIAL SECURITY NO.<br><i>579-09-5256</i>                      |  | 17. INFORMANT<br><i>Norman G. Tice</i>   |  | 17a. ADDRESS<br><i>1905 Waterford Lane District Hgts., Md.</i>                      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE <i>Arteriosclerotic cardiovascular disease with myocardial infarction</i><br><i>429.2</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.                                |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.   |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)         |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |   |  |  |  |   |  |  |  |
| ACTUAL SIGNATURE <i>August P. Rodriguez</i>   |  |  |  | DATE (SPECIFY) <i>6-4-79</i>  |  |  |  | MEDICAL EXAMINER  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <i>August P. Rodriguez</i>  |  |  |  | ADDRESS <i>5009 Rayburn Ct., Camp Springs, Pr. George, Md.</i>      |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>6/6/79</i>                 |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Maryland Veterans Cem.</i> |  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Cheltenham Pr. Geo. Md.</i>        |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>George P. Kalas Funeral Home Oxon Hill, Md.</i>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>JUN 6 1979</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>History Kelly</i>                                  |  |  |  |



98-2-3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |                                   |   |           |
|---|--|---|--|--|--|--|--|-----------------------------------|---|-----------|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 79 15666  |  |  |  |  |  |                                   |   |           |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   |  |  | 2a. DATE OF DEATH  |  |  |                                   |   | 2b. HOUR  |
| EDWARD TIMMINS  |  |   |  |  | JUNE 9 1979  |  |  |                                   |   | 6:58 P.M. |
| 3 SEX   |  | 4 RACE  |  | 5. DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                                   |  | IF UNDER 1 YEAR                   |   |           |
| MALE  |  | WHITE   |  | MONTH DAY YEAR<br>JANUARY 20 1927  |  | 52 YRS.  |  | IF UNDER 24 HRS.                  |   |           |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                              |  |                                   |   |           |
| PENNSYLVANIA  |  | U.S.A.  |  |  |  | PRINCE GEORGES COUNTY MD.  |  |                                   |   |           |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |           |
| ANDREWS AIR FORCE BASE  |  | MALCOLM GROW USAF MEDICAL CENTER  |  |  |  | USAF   |  | retired MILITARY                  |   |           |
| 13a. STATE  |  |   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |                                   | 13d. INSIDE CITY LIMITS?  |           |
| MARYLAND  |  |   |  |  | PRINCE GEORGES   |  | FRIENDLY   |                                   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |           |
| 14. FATHER'S NAME   |  |   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |                                   |   |           |
| FIRST MIDDLE LAST<br>ADOLPH TIMMINS   |  |   |  |  | FIRST MIDDLE LAST<br>LADISLAVA MIEDZIUS  |  |  |                                   |   |           |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |                                   |   |           |
| YES   |  |   |  |  | 1945-1964  |  | 207-14-0918  |                                   |   |           |
|   |  |   |  |  | MICHAEL R. (SON) 433 PLAINVIEW, EDGEWATER MD.  |  |  |                                   |   |           |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4275 IMMEDIATE CAUSE (a) Cardiac Arrest   |  |   |  |  |  |  |  |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1                |           |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |  |  |  |  |  |                                   |   |           |
| DUE TO, OR AS A CONSEQUENCE OF (b)  |  |   |  |  |  |  |  |                                   |   |           |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |  |  |  |  |                                   |   |           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |                                   |   |           |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  |  | 20a. AUTOPSY?  |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |           |
|   |  |   |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |           |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)             |  |  |                                   |   |           |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |                                   |   |           |
| 22a. I certify that (I) (this hospital) attended the deceased from 9 JUN 1979, to 9 JUN 1979, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |                                   |   |           |
| 22b. SIGNATURE<br>Bradford H. Lee   |  |   |  |  | DEGREE<br>MD   |  |  | 22c. DATE SIGNED<br>9 JUN 79      |   |           |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>BRADFORD H. LEE, CAPT, USAF, MC  |  |   |  |  | 22e. ADDRESS<br>MALCOLM GROW USAF MEDICAL CENTER<br>ANDREWS AIR FORCE BASE, MARYLAND 20331 |  |  |                                   |   |           |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE               |                                   |   |           |
| Burial  |  |   | 6-13-1979  |  | Arlington, National  |  | Fort Meyer Arlington Va.                                 |                                   |   |           |
| 24. FUNERAL DIRECTOR<br>NAME  |  |   |  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                               |                                   |   |           |
| Loyd P. Palus 6160 Oxon Hill Rd   |  |   |  |  | JUN 12 1979  |  | Loyd P. Palus  |                                   |   |           |

BP




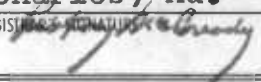
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH - 16 3/72 25M  
(VR A15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 5 6 3 7

|   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Howard G. Tippet</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>June</b> Day <b>25</b> Year <b>1979</b>   |   |  | 2b. HOUR <b>11:53</b> P   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>Oct. 28, 1905</b>  |  | 6. AGE (In years<br>lost birthday)<br><b>73</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>District of Columbia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Prince George's</b> Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Clinton</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Southern Md. Hospital Center</b> |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Inspector (County) Pr. Works</b>                           |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>Geo. Works</b>                                       |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Pr. Geo's Cheltenham</b>   |   | 13c. CITY OR TOWN<br><b>Cheltenham</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>10301 Frank Tippet Rd.</b>  |  |
| 14. FATHER'S NAME First Middle Last<br><b>P. Frank Tippet, Sr.</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>G. Irene Townshend</b> |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)                           |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>577-42-6318</b>  |  |  | 17. INFORMANT<br><b>10301 Frank Tippet Rd., Cheltenham, Md.</b>         |   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>20623              |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION (RECURRENT)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>atherosclerotic coronary heart disease.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>cardiomegaly</b>   |  |  |   |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>hours<br>years.<br>years.                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>degenerative joint disease. aspiration pneumonia.</b>   |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |  |
| 21a. ACCIDENT WAS<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)<br>UNDERLYING <input type="checkbox"/>   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 22, 1979</b> , to <b>June 25, 1979</b> , that (I) (we) last<br>saw the deceased alive on <b>June 25, 1979</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><br>DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |   |   |  | 22c. DATE SIGNED<br><b>6/26/79</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Peter W. S. Yim, M.D.</b>  |  |  |   |   |  | 22e. ADDRESS<br><b>7900 Old Branch Ave, Suite 101<br/>Clinton, Maryland</b>                     |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>6/28/79</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Trinity Mem. Gardens</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Waldorf (Charles) Md.</b>                   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Richard A. Coleman-Upper Marlboro,<br/>Funeral Home Maryland 20870:</b>  |  |  |   |   |  | 25a. REC'D BY REGISTRAR<br><b>JUL 10 1979</b>   |  | 25b. REGISTERED<br> |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  | REG. NO. 15638  |  |
|---|--|--|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2a. DECEASED NAME FIRST MIDDLE LAST<br>Stephen M. Totoro   |  |   |  |   |  | 2b. DATE OF DEATH MONTH DAY YEAR<br>June 21, 1979  |  | 2c. HOUR<br>12:20 P.M.                                |  |
| 3 SEX<br>Male   |  | 4 RACE<br>Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Feb 26, 1897   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>82 YRS.  |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Italy  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince George MD.                                       |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Cheverly   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>P. G. Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Tile Setter                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction  |  |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>PG  |  | 13c. CITY OR TOWN<br>Landover   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3322 Dodge Park Road  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Marco M. Totoro  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Concetta Delucci  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>578 46 3401  |  | 17. INFORMANT ADDRESS<br>Elizabeth M. Totoro (spouse) Same as #13C  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC-RESPIRATORY FAILURE</u><br>2050<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOBLASTIC LEUKEMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1-DAY</u> |  |  |  |   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6/18</u> , 19 <u>79</u> , to <u>6/21</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>6/21</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Max M. Herzyberg</u> M.D.  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br><u>6/22/79</u>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>MAX M. HERZBERG</u>   |  |  |  | 22e. ADDRESS<br><u>LANDOVER, MD. 20785</u>  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>Burial</u>  |  | 23b. DATE<br><u>6-25-79</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill Cemetery</u>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><u>Suitland PG Md</u>                                |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><u>Robert E. Wilhelm</u>   |  |  |  | ADDRESS<br><u>Suitland, Md.</u>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>JUN 27 1979</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Anthony McCreedy</u> |  |

BP







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

|   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Margaret Katharine TOWNSHEND   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06-23-79                       |   |  | 2b. HOUR<br>3:50 AM   |  |  |  |
| 3 SEX<br>Female   |  | 4 RACE<br>White  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>April 2, 1902  |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>77 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGES MD.                                      |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>CHEVERLY   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PRINCE GEORGES GENERAL HOSPITAL |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Space Controller            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Treasury   |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Prin. Georg.  |   | 13c. CITY OR TOWN<br>New Carrollton   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>5326 85th. Avenue   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Ernest ----- Townshend  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret ----- Leary |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]<br>No  |  | 16b. SOCIAL SECURITY NO.<br>577-60-3945  |   | 17. INFORMANT<br>ADDRESS<br>Martha L. Littleton, Towson, Md. 21204  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cardio Respiratory failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Metastatic carcinoma of lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Approximate interval between onset and death:<br>Minutes<br>Years    |  |  |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET<br>CITY OR TOWN<br>COUNTY<br>STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-18-</u> 19 <u>79</u> , to <u>6-22-</u> 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>6-22-</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>HEMA P. YADLA</u>  |  |  |   | DEGREE<br>M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  | 22c. DATE SIGNED<br>6/23/79  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>HEMA P. YADLA  |  |  |   | 22e. ADDRESS<br>4410. 74th Avenue<br>HYATTSVILLE - M.D. 20784   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>burial  |  | 23b. DATE<br>6/26/79   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oakland Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN<br>COUNTY<br>STATE<br>Oakland, Garrett, Maryland                  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Bradley A. Stewart  |  |  |   | ADDRESS<br>Oakland, Maryland 21550  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 29 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>P. H. McCreedy</u>  |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15640

|  |  |   |  |   |   |  |   |  |   |  |
|--|--|---|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>James B. Tuck</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 20, 1979</b>              |   |   | 2b. HOUR<br><b>3:40A</b> M   |   |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 6, 1919</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS                                     |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Pr. Geo. Co.</b> MD.                      |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pr. Geo. Gen. Hosp.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Firestone Tire Co.</b>   |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  |   |  |   | 13b. COUNTY<br><b>P.G.</b>  |  | 13c. CITY OR TOWN<br><b>Hyattsville</b>               |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Tuck</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Annie Cates</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>W.W.II</b> |   | 17. INFORMANT<br><b>Mary A. Tuck</b>  |  | ADDRESS<br><b>Address Same as No # 13e.</b>           |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br>410-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPERTENSION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)  |  |   |  |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19               |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>7-10-</b> 19 <b>77</b> , to <b>6-20-</b> 19 <b>79</b> , that (1) (we) last saw the deceased alive on <b>5-18-</b> 19 <b>79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.  |  |   |  |   |   |  |   |  |   |  |
| 22b. SIGNATURE<br><b>K. Joseph Mathew, MD.</b>   |  |   |  |   | DEGREE<br><b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>6-20-79</b>                    |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>K. Joseph Mathew, MD. PA.</b>  |  |   |  |   | 22e. ADDRESS<br><b>3700 East-West Highway St. 100 Hyattsville Md. 20786</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>6-23-79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood P.G. Md.</b>              |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 22 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patrick McCreedy</b> |  |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



U F O C I R A

| Date | File | October 6, 1959 |
|------|------|-----------------|
|------|------|-----------------|

100.000 100.000 100.000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |  |   |                                   |  |
|---|--|---|--|--|--|--|---|-----------------------------------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |  |  |  |   |                                   |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST   |  |   |  |  | 2a DATE OF DEATH MONTH DAY YEAR                          |  |   |                                   |  |
| BABY BOY UMBERGER   |  |   |  |  | 06 04 79 5:00P.M.  |  |   |                                   |  |
| 3 SEX   |  | 4 RACE  |  | 5 DATE OF BIRTH MONTH DAY YEAR   |  | 6 AGE (IN YEARS LAST BIRTHDAY)                               |   | 7 IF UNDER 1 YEAR IF UNDER 24 HRS |  |
| Male  |  | Caucasian   |  | 06 04 79   |  | N.B  |   | MONTHS DAYS HOURS MIN.            |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                          |   |                                   |  |
| U.S.A. Md.  |  | U.S.A.  |  |  |  | Prince Georges MD.   |   |                                   |  |
| 10 CITY OR TOWN OF DEATH  |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)         |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b KIND OF BUSINESS OR INDUSTRY  |  |
| Clinton   |  | Southern Maryland Hospital  |  |  |  |  |   |                                   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  |  |  |  |   |                                   |  |
| 13a STATE   |  | 13b COUNTY  |  | 13c CITY OR TOWN   |  | 13d INSIDE CITY LIMITS?                                      |   | 13e STREET ADDRESS                |  |
| Md.   |  | Pr.Geo.   |  | Forrestville   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>     |   | 7176 Donnell Place                |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST  |  |   |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST                |  |   |                                   |  |
| David Umberger  |  |   |  |  | Mary Koontz  |  |   |                                   |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17 INFORMANT ADDRESS   |  |  |   |                                   |  |
|   |  |   |  |  |  |  |   |                                   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  |   |  |  |  |  |   |                                   |  |
| IMMEDIATE CAUSE (a) <i>Respiratory &amp; Cardiac Arrest</i>   |  |   |  |  |  |  |   |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Choking &amp; Prematurity</i>   |  |   |  |  |  |  |   |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |   |  |  |  |  |   |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |  |  |  |   |                                   |  |
|   |  |   |  |  |  |  |   |                                   |  |
| 19a DATE OF OPERATION   |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a AUTOPSY?   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |  |
|   |  |   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |                                   |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |                                   |  |
|   |  | P.M. 19   |  |  |  |  |   |                                   |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |                                   |  |
|   |  |   |  |  |  |  |   |                                   |  |
| 22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |   |                                   |  |
| 22b SIGNATURE   |  | DEGREE ATTENDING PHYSICIAN MEDICAL STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |  |  |  |  | 22c DATE SIGNED   |                                   |  |
|   |  |   |  |  |  |  |   |                                   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  |   |  |  | 22e ADDRESS  |  |   |                                   |  |
| O. DE CANDIDO MD  |  |   |  |  | Southern Maryland Hosp.                                  |  |   |                                   |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b DATE  |  | 23c NAME OF CEMETERY OR CREMATORY  |  | 23d LOCATION CITY OR TOWN COUNTY STATE                       |   |                                   |  |
| Cremation   |  | 6/6/79  |  | Southern Md Hospital   |  | Clinton, Maryland 20735                                      |   |                                   |  |
| 24 FUNERAL DIRECTOR NAME ADDRESS  |  |   |  |  | 25a DATE REC'D. BY REGISTRAR                             |  | 25b REGISTRAR'S SIGNATURE                                     |                                   |  |
|   |  |   |  |  | JUN 12 1979  |  | P. McCready   |                                   |  |

1 3 0 4 1



UNITED STATES DEPARTMENT OF THE INTERIOR

UNITED STATES

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15642

|   |         |  |                   |   |                  |   |  |  |  |
|---|---------|--|-------------------|---|------------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | 2a. DATE KNOWN OF DEATH                                  |                   | 2b. DATE OF DEATH   |                  | 2c. DATE PRONOUNCED DEAD  |  | 2d. HOUR                                     |  |
| FIRST MARY M. VIRDEN  |         | MONTH DAY YEAR 6-22 1979                                 |                   | MONTH DAY YEAR 6-22 1979                                      |                  | MONTH DAY YEAR 6-22 1979  |  | HOUR 1545                                    |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (IN YEARS) | IF UNDER 1 YR.  | IF UNDER 24 HRS. | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)                                 |  | 7b. CITIZEN OF WHAT COUNTRY?                 |  |
| Female  | White   | 1-3-9  | 70                |   |                  | Missouri  |  | U.S.A.                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?                             |                   | 8. MARRIED  |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                      |  | 10. CITY OR TOWN OF DEATH                    |  |
| Missouri  |         | U.S.A.   |                   | WIDOWED   |                  | Jarmie George   |  | Lanham                                       |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |                  | 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. STATE                                   |  |
| Lanham  |         | Doctor's Hospital  |                   | Homemaker   |                  | Home  |  | Maryland                                     |  |
| 13a. STATE  |         | 13b. COUNTY  |                   | 13c. CITY OR TOWN   |                  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                          |  |
| Maryland  |         | Prince George  |                   | Bowie   |                  | YES   |  | 13006 Midsummer Lane                         |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME                                 |                   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                  |                  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT                                |  |
| Henry   |         | Lula   |                   | No  |                  | 218-54-9422   |  | Patricia V. Lucas                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |         | 16b. SOCIAL SECURITY NO.                                 |                   | 17. INFORMANT   |                  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| No  |         | 218-54-9422  |                   | Patricia V. Lucas   |                  | 2231 Hindle Lane, Bowie, Maryland   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         | 19a. DATE OF OPERATION                                   |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |                  | 20. AUTOPSY?  |  |  |  |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u>                                      |         | 4392   |                   |   |                  | YES   |  | NO   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |                   |   |                  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |                   |   |                  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |         |  |                   |   |                  |   |  |  |  |
| Obesity, hypertension   |         |  |                   |   |                  |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |         | 21b. TIME OF INJURY                                      |                   | 21c. HOW INJURY OCCURRED                                      |                  | 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY                         |  |
|   |         | HOUR A.M. MONTH DAY YEAR                                 |                   | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)          |                  | WHILE AT WORK   |  | STREET CITY OR TOWN COUNTY STATE             |  |
|   |         | P.M. 19  |                   |   |                  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from:                                      |         | Autopsy  |                   | Inspection  |                  | Inquiry   |  | and in my opinion                            |  |
| Natural causes  |         |  |                   |   |                  |   |  |  |  |
| Accident  |         |  |                   |   |                  |   |  |  |  |
| Suicide   |         |  |                   |   |                  |   |  |  |  |
| Homicide  |         |  |                   |   |                  |   |  |  |  |
| Undetermined manner   |         |  |                   |   |                  |   |  |  |  |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)  |                   | DATE SIGNED   |                  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                 |  | 23b. DATE                                    |  |
| Augusto P. Rodriguez  |         | Deputy MEDICAL EXAMINER                                  |                   | 6-23-79   |                  | Burial  |  | 6/26/79                                      |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         | ADDRESS  |                   | 23c. NAME OF CEMETERY OR CREMATORY                            |                  | 23d. LOCATION   |  | 23e. DATE REC'D. BY REGISTRAR                |  |
| Augusto P. Rodriguez, M.D.  |         | 5009 Rayburn Ct., Camp Springs, Md. 20031                |                   | Arlington Nat'l. Cem.   |                  | Arlington, Virginia   |  | JUN 27 1979                                  |  |
| 24. FUNERAL DIRECTOR  |         | 25. REGISTRATION   |                   | 26. REGISTRATION  |                  | 27. REGISTRATION  |  | 28. REGISTRATION                             |  |
| Robert A. Pumphrey  |         | Funeral Homes, P.A.                                      |                   | 7557 Wisconsin Ave., Bethesda, MD                             |                  | JUN 27 1979   |  | JUN 27 1979                                  |  |



MEMORANDUM FOR THE DIRECTOR

SUBJECT: [Illegible]

DATE: [Illegible]

TO: [Illegible]

FROM: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

[Illegible]

100%

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |   |  |  |  |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>IRA C WAMSLEY</b>  |  |  |  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><b>06 22 79</b>  |  | 2b HOUR<br><b>5:20A.M.</b>   |  |
| 3 SEX<br><b>Male</b>   |  | 4 RACE<br><b>Caucasian</b>   |  | 5 DATE OF BIRTH MONTH DAY YEAR<br><b>01 11 05</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS<br><b>74</b>   |  | 7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  |  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges MD</b>                           |  |  |  |
| 10 CITY OR TOWN OF DEATH<br><b>Clinton</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTHERN MARYLAND HOSPITAL CENTER</b> |  |  |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired - Railroad</b> |  | 12b KIND OF BUSINESS OR INDUSTRY   |  |
| 13a STATE<br><b>D.C.</b>   |  | 13b COUNTY<br><b>Washington</b>  |  | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e STREET ADDRESS<br><b>1619 Ft. Davis Place</b>   |  |  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br><b>Walter Wamsley</b>  |  |  |  | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Fannie Duffey</b>  |  |   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |  |  | 16b SOCIAL SECURITY NO.<br><b>719-01-2935</b>  |  | 17 INFORMANT ADDRESS<br><b>Above Charlotte Wamsley, Wife, Same as</b>                     |  |  |  |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Severe Respiratory - Cardiac Arrest</b><br><b>496 -</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Obstructive Heart Failure!</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Moderate Chronic Obstructive Pulmonary</b><br>PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH <b>Diabetes</b> |  |  |  |  |  |   |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from <b>6/18</b> 19 <b>79</b> to <b>6/22</b> 19 <b>79</b> , that (I) (we) lost <b>now the deceased alive on 6/21 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) did (did not) view the body after death.  |  |  |  |  |  |   |  |  |  |
| 22b SIGNATURE<br><b>Robert E. Wilhelm</b>  |  |  |  | DEGREE<br><b>MD</b>  |  | 22c DATE SIGNED<br><b>6/22/79</b>   |  |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. E. WILHELM</b>   |  |  |  | 22e ADDRESS<br><b>CHARLES PROSPER BLDG. WILMINGTON MD</b>  |  |   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b DATE<br><b>6-25-79</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cem.</b>  |  | 23d LOCATION CITY OR TOWN<br><b>Suitland</b>  |  | 23e COUNTY STATE<br><b>P.G. Md.</b>  |  |
| 24 FUNERAL DIRECTOR NAME<br><b>Robt E Wilhelm</b>  |  |  |  | ADDRESS<br><b>4308 Suitland Rd., Suitland, Md.</b>   |  | 25a DATE REC'D. BY REGISTRAR<br><b>JUN 27 1979</b>  |  | 25b REGISTRAR'S SIGNATURE<br><i>Robert E. Wilhelm</i>  |  |

00001 11



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 AND 2. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |                           | REG. NO. 15644  |  |
|--|--|--|--|--|--|--|--|---|---------------------------|---|--|
| 1- FOR STATE REGISTRAR   |  |  |  |  |  |  |  |   |                           |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>James Leroy Waters</b>  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 13 1979</b> |  | 2b. HOUR <b>M</b>   |                           |   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Black</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>May 9, 1924</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.   |  | 7. IF UNDER 1 YR. MONTHS DAYS   |                           | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>6 14 1979</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. COUNTRY OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Prince George's County, MD</b>                                   |  |   | 2d. HOUR <b>11:00 A M</b> |   |  |
| 10. CITY OR TOWN OF DEATH <b>Upper Marlboro</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4800 Block of Moores Way</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farming</b>                             |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                           |   |  |
| 13a. STATE <b>Md.</b>  |  | 13b. COUNTY <b>Pr. Geo.</b>  |  | 13c. CITY OR TOWN <b>Landover</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  | 13e. STREET ADDRESS <b>3012 Bright Seat Rd.</b>   |                           |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>William D. Waters</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Ella F. Newman</b>  |  |  |  |   |                           |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>  |  |  |  | 16b. SOCIAL SECURITY NO. <b>218-12-7695</b>  |  | 17. INFORMANT <b>Mrs. Marie F. Waters</b>  |  |   | ADDRESS <b>SAA</b>        |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Mechanical Compression</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>8160</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |  |  |  |  |  |  |  |   |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |  |  |   |                           |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                           |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>? P.M. 6 13 1979</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Farm tractor overturned pinning driver</b> |                           |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>  |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>4800 Moores Way, Upper Marlboro, Prince George's, Md.</b>           |                           |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |   |                           |   |  |
| ACTUAL SIGNATURE <b>Margaret A. Korell</b>   |  |  |  | TITLE (SPECIFY) <b>Assistant</b>   |  |  |  | DATE SIGNED <b>6/15/79</b>  |                           |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |  |  |  | ADDRESS <b>111 Penn Street</b>   |  |  |  |   |                           |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |  |  | 23b. DATE <b>6/20/79</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery Clinton</b>                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>P.G. Md.</b>   |                           |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Martell Adams Box 185 Aquasco, Md.</b>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1979</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>   |                           |   |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH79 15645  
REG. NO.1- FOR  
STATE  
REGISTRAR

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><u>John Henry Wedge</u>  |  |  | 2a DATE OF DEATH MONTH DAY YEAR<br><u>6 10 79</u>                                 |  | 2b HOUR<br><u>5<sup>10</sup> A.M.</u>            |
| 3 SEX<br><u>Male</u>   | 4 RACE<br><u>Negro</u>   | 5. DATE OF BIRTH MONTH DAY YEAR<br><u>2 19 19</u>  |   | 6 AGE (IN YEARS LAST BIRTHDAY)<br><u>60</u> YRS  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><u>Md.</u>   | 7b CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><u>Prince Georges</u> MD.                               |  |
| 10 CITY OR TOWN OF DEATH<br><u>Upper Marlboro</u>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>15408 Old Marlboro Pk.</u> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Cashier</u> |  | 12b KIND OF BUSINESS OR INDUSTRY<br><u>Store</u> |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b STATE<br><u>Md.</u> |  | 13c CITY OR TOWN<br><u>Prince Georges Upper Marlboro</u>   |   | 13d INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>William Francis Wedge</u>  |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Emma Theresa Mackle</u>   |   |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>No</u>                                       |  | 16b SOCIAL SECURITY NO.<br><u>577-14-1712</u>  |   | 17 INFORMANT<br>ADDRESS<br><u>Mamie Wedge (wife) Same address</u>                              |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

410-  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19a DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <u>19</u>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)      |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                   |  |
| 22a I certify that (I) (this hospital) attended the deceased from <u>June 19 79</u> to <u>June 19 79</u> , that (I) (last saw the deceased alive on <u>June 19 79</u> ), and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Clark Holmes, D.D.</u>   |  | DEGREE   |  | 22c. DATE SIGNED<br><u>6/10/79</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>A. Clark Holmes</u>   |  | 22e. ADDRESS<br><u>14314 Old Marlboro Pk. Upper Marlboro</u>           |  |   |  |

|   |                                   |  |  |
|---|-----------------------------------|--|--|
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>                  | 23b. DATE<br><u>June 15, 1979</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Resurrection Cem.</u> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Clinton Co. Md.</u> |
| 24 FUNERAL DIRECTOR<br>NAME ADDRESS<br><u>Tollins Funeral Home, Inc. 4339</u> |                                   | 25a. DATE REC'D. BY REGISTRAR<br><u>JUN 18 1979</u>            | 25b. REGISTRAR'S SIGNATURE<br><u>Harry Walcott</u>                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



AMERICAN

STATION





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 79 15646

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| FOR<br>1 - STATE<br>REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Evan Wesley -  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>6 7 79   |  | 2b. HOUR<br>9:54 AM  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>June 23, 1906   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince Georges MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Cheverly   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Pr. Geo. Gen. Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Pr. Geo  |  | 13c. CITY OR TOWN<br>Laurel  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>EVAN Wesley SR.  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Matilda CARTER  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>yes  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br>WWII 213-05-1921   |  |
| 16c. ADDRESS<br>Elva Wesley (wife) same as #13  |  | 17. INFORMANT<br>ADDRESS  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Uremia<br>185-<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Carcinoma of prostate -<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 days<br>7+ yrs.   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June 7, 1979, to June 7, 1979, that (I) (we) last saw the deceased alive on June 6, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>J. D. Francis   |  | DEGREE<br>MD  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  | 22c. DATE SIGNED<br>6/7/79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JACK D. FRANCIS  |  | 22e. ADDRESS<br>6911 Laurel-Bowie Rd, Bowie, Md.  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>6-13-79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Md. Nat'l Mem. Pk.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel Pr. Geo. Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George R. Snowden   |  | ADDRESS<br>346 N. WASH<br>Rockville, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 11 1979   |  | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |
|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 1 5 6 4 7  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 20. DATE OF DEATH  |  |
| FIRST MIDDLE LAST<br>Jack F. West   |  | MONTH DAY YEAR<br>6 5 79   |  |
| 21. SEX   |  | 22. HOUR   |  |
| Male  |  | 0845 M   |  |
| 3. SEX  |  | 4. RACE  |  |
| Male  |  | Black  |  |
| 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| MONTH DAY YEAR<br>2-9-25  |  | 54 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |
| Georgia   |  | USA  |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |
| Riverdale   |  | Eugene Leland Memorial   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| LABORER   |  | Prime Geo. Co. Dist  |  |
| 13a. STATE  |  | 13b. COUNTY  |  |
| Maryland  |  | Prince George's  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |
| HARRY WEST  |  | KATE MCNIEL  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  |
| YES   |  | 578386706  |  |
| 17. INFORMANT   |  | ADDRESS  |  |
| QUANITA WEST  |  | Same as above  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| IMMEDIATE CAUSE (a) Carcinomatosis  |  | 2 weeks  |  |
| 1509  |  | 1 month  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Squamous cell carcinoma of esophagus   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |
| Pneumonitis   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
|   |  |  |  |
| 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |
|   |  | P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  | 21d. INJURY OCCURRED   |  |
|   |  | WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>     |  |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION  |  |
|   |  | STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-26 19 79, to 6-5 19 79, that (I) (we) lost saw the deceased alive on 6-5 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  |
| C. J. Houmann   |  | 6-5-79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |
| C. J. Houmann, M.D.   |  | 4404 Queensbury Rd., Riverdale, Md. 20840  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  |
| Burial  |  | 6-11-79  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION  |  |
| CHEL-TEN-HAN VA. CEM  |  | CITY OR TOWN COUNTY STATE<br>CHEL-TEN-HAN Md.  |  |
| 24. FUNERAL DIRECTOR NAME   |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| T. RAZIER   |  | JUN 12 1979  |  |
| 25b. REGISTRAR'S SIGNATURE  |  |  |  |
| 389 P.F. G. H. W. Work, D.C. 20001  |  |  |  |



Book 2-8-24

Page 114

THE HARRY WEST KATE MCNEIL  
150 WEST STREET, NEW YORK

✓

C. J. [unclear]

11-11-11 CHESTERMAN [unclear] CITY [unclear]  
JUL 13 1918



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

15648

|  |   |   |  |   |   |
|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>THERESA M. WESTCAMP</b>   |   |   | 2a. DATE OF DEATH<br>MONTH <b>6</b> DAY <b>3</b> YEAR <b>79</b> 2b. HOUR <b>12:30 PM</b> |   |   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>CAUCASIAN</b>   | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>31</b> YEAR <b>99</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS   |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>PRINCE GEORGE'S</b> MD.                       |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>CLINTON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SOUTHERN MD HOSP CENTER</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |
| 13a. STATE<br><b>MD</b>  |   | 13b. COUNTY<br><b>P.G.</b>  | 13c. CITY OR TOWN<br><b>BRANDYWINE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>12406 MORANO DR.</b>  |
| 14. FATHER'S NAME<br>FIRST <b>Allen P.</b> MIDDLE <b>Kerby</b> LAST <b></b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Annie</b> MIDDLE <b>King</b> LAST <b></b>           |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>579-60-5418</b>  |  | 17. INFORMANT<br><b>Mechanicsville, Maryland</b><br><b>Kirby W. Westcamp Rt. 4 Box 456A</b>     |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Kidney Failure</b><br><b>2500</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus</b>                              |   |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>3 Wks</b><br><b>YEARS</b><br><b>YEARS</b>                               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |   |   |  |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 19 68</b> to <b>June 3 19 79</b> , that (I) (we) last saw the deceased alive on <b>June 2 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |   |   |  |   |   |
| 22b. SIGNATURE<br><b>Thomas L. Feldman M.D.</b>  |   |   |  | 22c. DATE SIGNED<br><b>June 1979</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   |   |  | 22e. ADDRESS  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |   | 23b. DATE<br><b>6/6/79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Resurrection Cemetery</b>                              |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Clinton P.G. Md.</b>  |   | 24. FUNERAL RECORD<br>NAME <b>Funeral Home Inc.</b> ADDRESS <b>6633 Old Alexander Ferry Rd. Clinton, Md.</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 8 1979</b>  |   |
|  |   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Patrick McCurdy</b>  |   |

35 75 35 14 1 9 9 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



• • •



Allen P. Kirby

Richard Cavell  
c/o Mrs. J. H. Cavell

None

1512

Doc. No. 100-1

• 600 mil. \$



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

(M)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 9 1 5 6 4 9

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |   |   |   |                      |                                |
|--|---|---|---|---|---|----------------------|--------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JAMES T WHITE   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06 11 79   |   |   | 2b. HOUR P<br>3:30 M |                                |
| 3. SEX<br>M  | 4. RACE<br>B  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 -25-1898   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>80 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS                    |                      | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Va.   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGE'S COUNTY MD.                              |   |   |                      |                                |
| 10. CITY OR TOWN OF DEATH<br>CHEVERLY  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>EXTENDED CARE FACILITY |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired                     |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Construction |                      |                                |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)                |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br>5113 Doppler St.           |                      |                                |
| 13a. STATE<br>Md.  | 13b. COUNTY<br>P.G.   | 13c. CITY OR TOWN<br>Cap. Hgts.   |   |   |   |                      |                                |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James White  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nellie Bundy                                   |   |   |                      |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No |   | 16b. SOCIAL SECURITY NO.<br>Unknown   |   | 17. INFORMANT<br>ADDRESS<br>Evelyn Dougherty-Same as # 13 above |   |                      |                                |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 436- ① senility ② CVA<br>DUE TO, OR AS A CONSEQUENCE OF (b) ③ Multiple scalt m...<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

|   |  |   |  |
|---|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>         | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-12-1979 to 6-12-1979, that (I) (we) last saw the deceased alive on 6-12-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |
| 22b. SIGNATURE<br>H. A. Melan   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>6.12.79   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>H. A. Melan  | 22e. ADDRESS<br>6005 Landover Rd Cheverly Md   |   |  |

|   |                      |   |   |
|---|----------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)            | 23b. DATE<br>6-15-79 | 23c. NAME OF CEMETERY OR CREMATORY<br>LINCOLN MEM. CEM. | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SUITLAND P.G. MD. |
| 24. FUNERAL DIRECTOR<br>NAME<br>H. S. WASHINGTON & SONS |                      | ADDRESS<br>4925 BURROUGHS AVE., N.E.                    | 25a. DATE REC'D. BY REGISTRAR<br>JUN 15 1979                    |
|   |                      | 25b. REGISTRAR'S SIGNATURE<br>Robert McCreary           |   |

BP



1 2 3 4 5 6 7 8 9 10 11 12

(M)

(M)

1 2 3 4 5 6 7 8 9 10 11 12

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be obtained by the hospital or attending physician.

1

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br><b>CERTIFICATE OF DEATH</b>   |  |  |  |  |  | REG. NO.<br><span style="font-size: 1.5em;">1 5 6 5 0</span>  |  |   |  |   |  |   |  |   |                                   |  |  |
|---|--|--|--|--|--|---|--|---|--|---|--|---|--|---|-----------------------------------|--|--|
| <b>1. DECEASED NAME</b><br><small>(TYPE OR PRINT)</small><br><b>SOPHIE</b>  |  |  | <b>FIRST</b><br><b>(NMI)</b>   |  |  | <b>MIDDLE</b><br><b>WIEBOLDT</b>  |  |   | <b>LAST</b><br><b>DT</b>   |   |  | <b>2a. DATE OF DEATH</b> MONTH DAY YEAR<br><b>6/2/79</b>  |  |   | <b>2b. HOUR</b><br><b>3:05A</b> M |  |  |
| <b>3. SEX</b><br><b>Female</b>  |  |  | <b>4. RACE</b><br><b>White</b>   |  |  | <b>5. DATE OF BIRTH</b><br><small>MONTH DAY YEAR</small><br><b>July 15, 1889</b>  |  |   | <b>6. AGE (IN YEARS LAST BIRTHDAY)</b><br><b>89</b> YRS.   |   |  | <b>IF UNDER 1 YEAR</b><br><small>MONTHS DAYS HOURS MIN.</small>   |  |   | <b>IF UNDER 24 HRS.</b>           |  |  |
| <b>7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)</b><br><b>Germany</b>  |  |  | <b>7b. CITIZEN OF WHAT COUNTRY?</b><br><b>USA</b>  |  |  | <b>8. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/> |  |   | <b>9. BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>PRINCE GEORGES COUNTY</b> MD.                                      |   |  |   |  |   |                                   |  |  |
| <b>10. CITY OR TOWN OF DEATH</b><br><b>RIVERDALE</b>  |  |  | <b>11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION</b><br><small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small><br><b>LELAND MEMORIAL HOSPITAL</b> |  |  |   |  |   | <b>12a. USUAL OCCUPATION</b><br><small>(TYPE OF WORK FOR MOST OF WORKING LIFE)</small><br><b>Housewife</b>           |   |  | <b>12b. KIND OF BUSINESS OR INDUSTRY</b><br><b>Home</b>   |  |   |                                   |  |  |
| <b>USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)</b><br><b>13a. STATE</b> <b>Maryland</b> <b>13b. COUNTY</b> <b>Pr. Geo's</b> <b>13c. CITY OR TOWN</b> <b>Hyattsville</b>   |  |  |  |  |  |   |  |   | <b>13d. INSIDE CITY LIMITS?</b><br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |   |  | <b>13e. STREET ADDRESS</b><br><b>5023 53rd Place</b>  |  |   |                                   |  |  |
| <b>4. FATHER'S NAME</b><br><small>FIRST MIDDLE LAST</small><br><b>H. Rodegerats</b>   |  |  |  |  |  |   |  |   | <b>15. MOTHER'S MAIDEN NAME</b><br><small>FIRST MIDDLE LAST</small><br><b>Johanna (Last Name Unknown)</b>            |   |  |   |  |   |                                   |  |  |
| <b>6a. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br><small>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)</small><br><b>No</b>  |  |  | <b>16b. SOCIAL SECURITY NO.</b><br><b>115-24-9693A</b>   |  |  | <b>17. INFORMANT</b> <b>ADDRESS</b><br><b>Martha Wieboldt (dau) same as blk 13e</b>   |  |   |  |   |  |   |  |   |                                   |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br><b>PART I. DEATH WAS CAUSED BY</b><br><b>IMMEDIATE CAUSE (a)</b> <b>Cardiac Failure</b><br><b>1889</b> DUE TO, OR AS A CONSEQUENCE OF<br><b>(b) Hepato Renal Failure</b><br><b>3 days</b><br><b>(c) Cancer of Bladder</b><br><b>6 yrs</b>  |  |  |  |  |  |   |  |   |  |   |  | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><b>1 wk</b>  |  |   |                                   |  |  |
| <b>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</b>   |  |  |  |  |  |   |  |   |  |   |  |   |  |   |                                   |  |  |
| <b>19a. DATE OF OPERATION</b>   |  |  |  | <b>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>                                      |  |   |  | <b>20a. AUTOPSY?</b><br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/> |  | <b>20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?</b><br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |   |  |   |                                   |  |  |
| <b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/><br><b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b><br><small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>  |  |  |  | <b>21b. TIME OF INJURY</b><br><small>HOUR A.M. MONTH DAY YEAR</small><br><b>P.M. 19</b>      |  |   |  | <b>21c. HOW INJURY OCCURRED</b> (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                     |  |   |  |   |  |   |                                   |  |  |
| <b>21d. INJURY OCCURRED</b><br><b>WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>  |  |  |  | <b>21e. PLACE OF INJURY</b><br><small>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</small> |  |   |  | <b>21f. LOCATION</b><br><small>CITY OR TOWN STREET COUNTY STATE</small>                                   |  |   |  |   |  |   |                                   |  |  |
| <b>22a. I certify that (I) (this hospital) attended the deceased from</b> <b>May</b> , 19 <b>73</b> , <b>to</b> <b>1 June</b> , 19 <b>79</b> , <b>that (I) (we) lost</b> <b>the deceased alive on</b> <b>1 June</b> , 19 <b>79</b> , <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.</b> |  |  |  |  |  |   |  |   |  |   |  |   |  |   |                                   |  |  |
| <b>23a. SIGNATURE</b><br><i>T.M. Hutchins</i>   |  |  |  |  |  |   |  | <b>DEGREE</b><br><b>M.D.</b>  |  |   |  | <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |  | <b>27. DATE SIGNED</b><br><b>6/2/79</b> |                                   |  |  |
| <b>23b. PHYSICIAN'S NAME (TYPE OR PRINT)</b><br><b>T.M. Hutchins</b>  |  |  |  |  |  |   |  | <b>23c. ADDRESS</b><br><b>6314 Landover Rd Hyattsville, Md 21188</b>                                      |  |   |  |   |  |   |                                   |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (SPECIFY)</b><br><b>Burial</b>   |  |  |  | <b>23b. DATE</b><br><b>6/7/79</b>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Lutheran Cemetery</b>   |  |   |  | <b>23d. LOCATION</b><br><small>CITY OR TOWN COUNTY STATE</small><br><b>Middle Village Queens, N.Y.</b>  |  |   |  |   |                                   |  |  |
| <b>24. FUNERAL DIRECTOR</b><br><b>NAME</b> <b>Francis Gasch's Sons, PA</b> <b>ADDRESS</b> <b>Hyattsville, Md.</b>   |  |  |  |  |  |   |  | <b>25a. DATE REC'D. BY REGISTRAR</b><br><b>JUN 11 1979</b>  |  |   |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><i>[Signature]</i>   |  |   |                                   |  |  |

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br><b>CERTIFICATE OF DEATH</b><br><span style="float: right;">REG. NO. <span style="font-size: 1.2em;">15650</span></span>   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|
| <b>1. DECEASED NAME</b><br><small>(TYPE OR PRINT)</small><br><b>SOPHIE</b>  |  |  |  | <b>FIRST</b><br><b>(NMI)</b>   |  |  |  | <b>MIDDLE</b><br><b>WIEBOLDT</b>  |  |  |  | <b>LAST</b><br><b>DT</b>  |  |  |  | <b>2a. DATE OF DEATH</b> MONTH DAY YEAR<br><b>6/2/79</b>        |  |  |  | <b>2b. HOUR</b><br><b>3:05A</b> M  |  |  |  |  |  |  |  |
| <b>3. SEX</b><br><b>Female</b>  |  |  |  | <b>4. RACE</b><br><b>White</b>   |  |  |  | <b>5. DATE OF BIRTH</b><br><small>MONTH DAY YEAR</small><br><b>July 15, 1889</b>  |  |  |  | <b>6. AGE</b> (IN YEARS LAST BIRTHDAY)<br><b>89</b> YRS.  |  |  |  | <b>IF UNDER 1 YEAR</b><br><small>MONTHS DAYS HOURS MIN.</small> |  |  |  |  |  |  |  |  |  |  |  |
| <b>7a. BIRTHPLACE</b> (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>  |  |  |  | <b>7b. CITIZEN OF WHAT COUNTRY?</b><br><b>USA</b>  |  |  |  | <b>8. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |  | <b>9. BALTIMORE CITY OR COUNTY OF DEATH</b><br><b>PRINCE GEORGES COUNTY</b> MD.   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| <b>10. CITY OR TOWN OF DEATH</b><br><b>RIVERDALE</b>  |  |  |  | <b>11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION</b><br><small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small><br><b>LELAND MEMORIAL HOSPITAL</b> |  |  |  |   |  |  |  | <b>12a. USUAL OCCUPATION</b><br><small>(TYPE OF WORK FOR MOST OF WORKING LIFE)</small><br><b>Housewife</b>  |  |  |  | <b>12b. KIND OF BUSINESS OR INDUSTRY</b><br><b>Home</b>         |  |  |  |  |  |  |  |  |  |  |  |
| <b>USUAL RESIDENCE</b> (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |  |  |  |  |   |  |  |  | <b>13a. STATE</b><br><b>Maryland</b>  |  |  |  | <b>13b. CITY OR TOWN</b><br><b>Pr. Geo's</b>                    |  |  |  | <b>13c. INSIDE CITY LIMITS?</b><br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |  |  |  | <b>13d. STREET ADDRESS</b><br><b>5023 53rd Place</b> |  |  |  |
| <b>4. FATHER'S NAME</b><br><small>FIRST MIDDLE LAST</small><br><b>H. Rodegerats</b>   |  |  |  |  |  |  |  | <b>15. MOTHER'S MAIDEN NAME</b><br><small>FIRST MIDDLE LAST</small><br><b>Johanna (Last Name Unknown)</b>   |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| <b>6a. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br><small>(YES, NO OR UNKNOWN)</small><br><b>No</b>  |  |  |  |  |  |  |  | <b>6b. SOCIAL SECURITY NO.</b><br><b>115-24-9693A</b>   |  |  |  | <b>17. INFORMANT</b><br><b>Martha Wieboldt (dau) same as blk 13e</b>  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))<br><b>PART I. DEATH WAS CAUSED BY</b>   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>             |  |  |  |  |  |  |  |  |  |  |  |
| <b>IMMEDIATE CAUSE (a)</b> <b>Cardiac Failure</b>   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  | <b>1 hr</b>   |  |  |  |  |  |  |  |  |  |  |  |
| <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b>   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  | <b>(b) Hepatic Renal Failure</b>                                |  |  |  | <b>3 days</b>  |  |  |  |  |  |  |  |
| <b>DUE TO, OR AS A CONSEQUENCE OF</b>   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  | <b>(c) Cancer of Bladder</b>                                    |  |  |  | <b>6 yrs</b>   |  |  |  |  |  |  |  |
| <b>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</b>   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| <b>19a. DATE OF OPERATION</b>   |  |  |  | <b>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>  |  |  |  | <b>20a. AUTOPSY?</b><br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>   |  |  |  | <b>20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?</b><br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>                 |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| <b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/><br><b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b><br><small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>  |  |  |  | <b>21b. TIME OF INJURY</b><br><small>HOUR A.M. MONTH DAY YEAR</small><br><b>P.M. 19</b>  |  |  |  | <b>21c. HOW INJURY OCCURRED</b> (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| <b>21d. INJURY OCCURRED</b><br><small>WHILE AT WORK</small> <input type="checkbox"/> <small>NOT WHILE AT WORK</small> <input type="checkbox"/>  |  |  |  | <b>21e. PLACE OF INJURY</b><br><small>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</small>   |  |  |  | <b>21f. LOCATION</b><br><small>CITY OR TOWN STREET COUNTY STATE</small>   |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| <b>22a. I certify that (I) (this hospital) attended the deceased from</b> <b>May</b> , 19 <b>73</b> , <b>to</b> <b>1 June</b> , 19 <b>79</b> , <b>that (I) (we) lost</b> <b>saw the deceased alive on</b> <b>1 June</b> , 19 <b>75</b> , <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.</b> |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| <b>23a. SIGNATURE</b><br><i>T.M. Hutchins</i>   |  |  |  |  |  |  |  | <b>DEGREE</b><br><b>M.D.</b>  |  |  |  | <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/> |  |  |  | <b>27. DATE SIGNED</b><br><b>6/2/79</b>                         |  |  |  |  |  |  |  |  |  |  |  |
| <b>23b. PHYSICIAN'S NAME</b> (TYPE OR PRINT)<br><b>T.M. Hutchins</b>  |  |  |  |  |  |  |  | <b>23c. ADDRESS</b><br><b>6314 Landover Rd Hyattsville, Md 21188</b>  |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| <b>23d. BURIAL, CREMATION, REMOVAL (SPECIFY)</b><br><b>Burial</b>   |  |  |  | <b>23e. DATE</b><br><b>6/7/79</b>  |  |  |  | <b>23f. NAME OF CEMETERY OR CREMATORY</b><br><b>Lutheran Cemetery</b>   |  |  |  | <b>23g. LOCATION</b><br><small>CITY OR TOWN COUNTY STATE</small><br><b>Middle Village Queens, N.Y.</b>  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| <b>24. FUNERAL DIRECTOR</b><br><b>Francis Gasch's Sons, PA Hyattsville, Md.</b>   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  | <b>25a. DATE REC'D. BY REGISTRAR</b><br><b>JUN 11 1979</b>      |  |  |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><i>[Signature]</i>  |  |  |  |  |  |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |                   |  |  |  |
|--|--|---|--|---|---|--|-------------------|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 7 9 15651<br>REG. NO.   |  |   |   |  |                   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>JOSEPH WILLIAMS   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06-04-79                   |  |                   | 2b. HOUR<br>12:41PM  |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 12 1899   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.   |                   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGES COUNTY MD.                    |                   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Prince George Hospital |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired          |                   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. STATE<br>Maryland   |  |   |  |   | 13b. COUNTY<br>Landover   |  | 13c. CITY OR TOWN |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry Williams   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pattie (unknown) |  |                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>190 03 9789  |  | 17. INFORMANT<br>ADDRESS<br>Mrs. Flossie Branch-niece-4531 Kinmon Road  |   |  |                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congestive Heart Failure<br>4440 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease 5 mos<br>(c) Hypertension 2 yrs |  |   |  |   |   |  |                   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTINUING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):   |  |   |  |   |   |  |                   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |                   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |                   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 19 19 to 6/4, 19 29, that (I) (we) lost saw the deceased alive on 6/4, 19 29, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |  |                   |  |  |  |
| 22a. SIGNATURE<br>Dr. Henry A. Wise, M.D.<br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  |   |   |  |                   | 22c. DATE SIGNED<br>6/5/79   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Henry A. Wise Sr.   |  |   |  | 22e. ADDRESS<br>Lanham Md   |   |  |                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>6/9/79   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Harmony Memorial Park   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Landover, Maryland                           |                   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Stewart Funeral Home-4001 Benning Road, NE.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 11 1979  |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature]  |                   |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                         |  |  |   |  |   |                         |  |  | 15652<br>REG. NO.                                   |  |
|---|-------------------------|--|--|---|--|---|-------------------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Allen Arnold WILLIAMSON</b>  |                         |  |  |   |  |   |                         |  |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <b>6-16-79</b> |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12-17-13</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>65</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS.   | 2c. DATE PRONOUNCED DEAD<br><b>6-16-79</b>  | 2d. HOUR<br><b>9:20</b> |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges</b>                                   |                         |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Andrews AFB</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Malcolm Grow Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>                 |                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U S Gov't</b>                    |  |   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                         |  |  |   |  |   |                         |  |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>PG</b>   |  | 13c. CITY OR TOWN<br><b>Forestville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                         | 13e. STREET ADDRESS<br><b>6142 Surrey Square Lane</b>                    |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harvey J. Williamson</b>   |                         |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sarah A. Pearson</b>  |  |   |                         |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>243 26 0742</b>         |   | 17. INFORMANT (spouse) ADDRESS<br><b>Frankie C. Williamson Same as #13</b> |   |                         |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4292 Arteriosclerotic cardiovascular disease</b><br>IMMEDIATE CAUSE (a) <b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |                         |  |  |   |  |   |                         |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                         |  |  |   |  |   |                         |  |  |   |  |
| 19a. DATE OF OPERATION  |                         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |                         | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                         |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |                         |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                         |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                         |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                         |  |  |   |  |   |                         |  |  |   |  |
| ACTUAL SIGNATURE<br><b>Augusto P. Rodriguez</b>   |                         |  |  | TITLE (SPECIFY)<br><b>Deputy</b> M.D. MEDICAL EXAMINER  |  |   |                         | DATE SIGNED<br><b>6-17-79</b>  |  |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Augusto P. Rodriguez, M.D.</b>   |                         |  |  | 5009 Rayburn Ct., Camp Springs, Md. 20031<br>ADDRESS  |  |   |                         |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |                         |  | 23b. DATE<br><b>June 20-79</b>                         |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cem.</b>             |   |                         | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood PG Md</b>     |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert E. Wilhelm</b><br><b>Funeral Home Inc</b>   |                         |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 22 1979</b>   |                         | 25b. REGISTRAR'S SIGNATURE<br><b>Robert E. Wilhelm</b>                   |  |   |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |  |  |  |  |  |   |  |   |  | REG. NO. 15653  |  |   |  |
|---|--|-------------------------|--|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Francis X WILSON</b>   |  |                         |  |  |  |  |  |   |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 6-24-79 |  | 2b. HOUR<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> 1979 |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b> |  | 5. DATE OF BIRTH<br>MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 2-28-28                    |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <input type="checkbox"/> YRS. 37                    |  | IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   |  | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN <input type="checkbox"/>           |  | 2c. DATE PRONOUNCED DEAD<br>MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 6-24-79           |  | 2d. HOUR<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> 1979 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wash., D.C.</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince Georges</b> MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Cheverly</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pr. Geo. Gen. Hosp.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Electrician</b>  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Union</b>   |  |   |  |
| 13a. STATE<br><b>Md.</b>  |  |                         |  | 13b. COUNTY<br><b>Pr. Geo.</b>   |  | 13c. CITY OR TOWN<br><b>Seat Pleasant</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>6702 - Wilburn Drive</b>  |  |   |  | Station   |  |
| 14. FATHER'S NAME<br>FIRST <b>Clifford</b> MIDDLE <b>Wilson</b> LAST <b>Wilson</b>  |  |                         |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Marguerite</b> MIDDLE <b>C.</b> LAST <b>Tholl</b> |  |   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>WW II</b>   |  | 17. INFORMANT<br><b>Betty M. Wilson (Wife)</b>   |  |   |  | ADDRESS<br><b>Same As Above</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Certain selected Cardiovascular disease</b><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                             |  |                         |  |  |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                         |  |  |  |  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  |                         |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                      |  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                         |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                             |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)             |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                         |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                            |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |  |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Augusto P. Rodriguez</b> M.D. Deputy  |  |                         |  |  |  | TITLE (SPECIFY)<br><b>M.D. Deputy</b>  |  |   |  |   |  | DATE SIGNED <b>6-25-79</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Augusto P. Rodriguez</b>   |  |                         |  |  |  | ADDRESS <b>5009 Rayburn Ct., Camp Springs</b>  |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |                         |  | 23b. DATE<br><b>6-29-79</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>                       |  |   |  | 23d. LOCATION<br>CITY OR TOWN <b>Washington, D.C.</b> COUNTY <b>MD</b> STATE <b>30131</b> |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Nalley's F.H. Inc.</b> ADDRESS <b>Mt. Rainier, Md.</b>  |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUL 2 1979</b>                                     |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Henry McCready</b>                                       |  |   |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 7 9 1 5 6 5 4  |  |   |  | REG. NO.   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR P M                                 |  |
| MAJOR J.C. WINSTON  |  |  |  |   |  |  |  | June 15, 1979   |  | 4.25 P M                                     |  |
| 3 SEX   |  | 4 RACE   |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7 IF UNDER 1 YEAR MONTHS DAYS   |  | 8 IF UNDER 24 HRS HOURS MIN                  |  |
| Male  |  | Black  |  | Jan 1 1905  |  | 74 YRS.  |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |  |  |
| Va.   |  | USA  |  |   |  | Prince Georges Co. MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| Lanham  |  | Doctors Hospital of Pr. Geo. Co.   |  |   |  |  |  | Retired   |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE   |  | 13c. COUNTY  |  | 13d. CITY OR TOWN   |  | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 13f. STREET ADDRESS   |  |  |  |
| Md.   |  | PG   |  | Lanham  |  |  |  | 5214 Galveston Road   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |   |  |  |  |
| Douglas Winston   |  |  |  | Isabel Wallace  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)  |  | 17. INFORMANT ADDRESS   |  |  |  |   |  |  |  |
| yes   |  | WWII   |  | 579-05-9190   |  |  |  | Celestina Winston SA Item 13e Wife  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident  |  |  |  |   |  |  |  |   |  | 3 days                                       |  |
| 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension  |  |  |  |   |  |  |  |   |  | 5 yrs  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Peripheral Vascular Disease  |  |  |  |   |  |  |  |   |  | 16 yrs                                       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes mellitus, Obesity  |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
|   |  |  |  |   |  |  |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |   |  |  |  |
|   |  | P.M. 19  |  |   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |  |  |
|   |  |  |  |   |  |  |  |   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 6/15, 19 79, to 6/15, 19 79, that (I) (we) lost saw the deceased alive on 6/15, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |  |  |
| 22a. SIGNATURE  |  | DEGREE   |  |   |  | ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED  |  |  |  |
| A. C. Wise Jr. M.D.   |  |  |  |   |  |  |  | 6/16/79   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |   |  |  |  |   |  |  |  |
| Henry A. Wise Jr.   |  | Lanham, Md.  |  |   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| Burial  |  | 6-20-79  |  | Ft. Lincoln   |  | Brentwood PG Md.   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR FRAZIER'S FUNERAL HOME 389 Rhode Island Ave., N.W.   |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |
|   |  |  |  |   |  | JUN 21 1979  |  | Henry A. Wise Jr.   |  |  |  |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4, 5, AND 6 TO THE MEDICAL EXAMINER. GIVE PAGES 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  | REG. NO. 15655   |  |  |  |
|---|--|---|--|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Ralph IVEY WOODWARD   |  |   |  |   |  |  |  |   |  | 2a. DATE KNOWN OF DEATH MONTH DAY YEAR<br>6-11-79  |  | 2b. HOUR<br>M                              |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7-15-16  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>62                             |  | IF UNDER 1 YR. MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>VIRGINIA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Prince Georges MD.             |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Chesley  |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>Prince Georges Gen. Hosp. Dist. |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERK |  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br>Maryland Prince Georges HYSTATTSVILLE   |  |   |  |   |  |  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>813 Sheridan Street |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>CLARENCE WOODWARD  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>JULIA IVEY  |  |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO |  |  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>579-18-3682   |  |   |  | 17. INFORMANT<br>ELIZABETH MARCELLINO   |  |  |  | ADDRESS<br>10405 HUNTER DRIVE OAKTON, VIRGINIA  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerosis Cordis Vasculat dilata</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF                             |  |   |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><u>Diabetes mellitus</u>  |  |   |  |   |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                               |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                       |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |   |  |   |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br>August P. Rodriguez   |  |   |  | TITLE (SPECIFY)<br>Deputy   |  |  |  | DATE SIGNED<br>6-11-79  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>August P. Rodriguez  |  |   |  | ADDRESS<br>1009 Rayburn Court, Camp Springs   |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>BURIAL   |  |   |  | 23b. DATE<br>6/13/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>NATIONAL MEMORIAL PARK           |  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>FALLS CHURCH VIRGINIA |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>FRANCIS J. COLLINS<br>500 UNIV. BLVD., W., SILVER SPRING, MARYLAND   |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 12 1979                           |  |   | 25b. REGISTRAR'S SIGNATURE<br>Rafael Rodriguez                   |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |   |   |   |   |  |
|--|--|--|---|--|---|---|---|---|--|
| 1. FOR STATE REGISTRAR   |  |  |   |  | 7. 9 15656  |   |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Jessie</b>   |  |  |   |  | 2a. DATE OF DEATH MONTH <b>6</b> DAY <b>9</b> YEAR <b>79</b> 2b. HOUR <b>9:45</b> AM  |   |   |   |  |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>WHITE</b>   |   | 5. DATE OF BIRTH MONTH <b>MAR.</b> DAY <b>5</b> YEAR <b>1918</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.                                    |   | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>                                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE'S COUNTY MD.</b>            |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PRINCE GEORGE'S GENERAL HOSPITAL</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>    |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>  |  |
| 13a. STATE <b>MARYLAND</b>   |  |  | 13b. COUNTY <b>PG</b>                       |  | 13c. CITY OR TOWN <b>BOWIE</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME FIRST <b>ABRAHAM</b> MIDDLE <b></b> LAST <b>PERLMAN</b>  |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>ROSE</b> MIDDLE <b></b> LAST <b>UNKNOWN</b>         |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO. <b>118-22-4719</b> |  | 17. INFORMANT <b>DR. LEONARD WOLFF</b><br><b>12615 BLACKWELL LA., BOWIE, MD 20715</b> |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma Colon with liver metastases</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b></b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last: <b></b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> |  |  |   |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b></b>  |  |  |   |  |   |   |   |   |  |
| 19a. DATE OF OPERATION <b>5/17/79</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>same as above</b>  |   |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b></b> P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b></b>   |   |   |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>  |   | 21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>   |   |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/15/79</b> to <b>6/9/79</b> , that (I) (we) last saw the deceased alive on <b>6/9/79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |   |   |   |   |  |
| 22b. SIGNATURE <b>Bertram Weisbaum</b> DEGREE <b>MD</b>  |  |  |   |  | 22c. DATE SIGNED <b>6/9/79</b>  |   |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Bertram Weisbaum</b>   |  |
| 22e. ADDRESS <b>6490 Landover Rd. Landover Park, Md.</b>   |  |  |   |  |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>JUNE 11, 1979</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>SHAAREI TFILOH</b>   |   | 23d. LOCATION <b>BALTIMORE</b> COUNTY <b></b> STATE <b>MARYLAND</b>               |   |   |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> NAME <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b> ADDRESS <b></b>   |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>JUN 13 1979</b>                                      |   | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>                                     |   |  |

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Medical Examiner Notified  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
Released By: Dr. Rodriguez  
3602

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 must be retained by the hospital or attending physician. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M  
(VRA 15, 4) 7/78

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 9 1 5 6 5 7<br>REG. NO.   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>CATHERINE E. YOUNG  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>06-12-79   |  | 2b. HOUR<br>8:20PM   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Black  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 17 27   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>PRINCE GEORGE'S COUNTY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>CHEVERLY  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>PRINCE GEORGE'S HOSPITAL |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Teacher   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Landover   |  | 13c. CITY OR TOWN<br>PG   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>George O. Beard  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sadie E. Madden  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220 24 6401  |  | 17. INFORMANT<br>ADDRESS<br>James E. Young-Husband-8803 Sterling St.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Overwhelming Sepsis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Diabetic Mellitus</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Chronic Hemolytic Disease</u><br>2500<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19 79   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>6-12</u> 19 <u>79</u> , to <u>6-12</u> 19 <u>79</u> , that (I) (we) lost<br>saw the deceased alive on <u>6-12</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><u>Robert Ruderman</u>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br>6/12/79  |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT RUDERMAN   |  |   |  | 22d. ADDRESS<br>6201 GREENBELT ROAD, COLLEGE PARK, MD. 20022  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>6/15/79  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Harmony Memorial Park   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Landover, Maryland   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Stewart Funeral Home-4001 Benning Road   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>JUN 18 1979  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Rob Brady</u>   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HELEN A. YOUNG</b>                          |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>June 16, 1979</b>                                   |   | 2b. HOUR<br><b>1:15A M</b>                            |
| 3 SEX<br><b>FEMALE</b>   | 4 RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 9, 1899</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.                         |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WASH DC.</b>                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>PRINCE GEORGE'S MD.</b>        |   |
| 10. CITY OR TOWN OF DEATH<br><b>LARGO</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MANOR CARE Nursing Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Telephone operator</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Govt</b> |
| 13a. STATE<br><b>MARYLAND</b>  |   |   | 13b. COUNTY<br><b>PR. GEORGE'S</b>  | 13c. CITY OR TOWN<br><b>Chesley</b>                                       |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Simpson</b>                      |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>AMANDA ANDERSON</b>                       |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO-</b> |   | 16b. SOCIAL SECURITY NO.<br><b>579-18-5008</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>HELEN STEVENS (DAUGHTER) SAME AS ABOVE</b> |   |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a). <b>CARDIAC ARRYTHMIA</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2 weeks</b> |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b). <b>CROHN'S DISEASE</b>   |  | <b>20 YEARS</b>   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c). <b>HYPO PHUOTROMBINOMIA</b>  |  | <b>5 DAYS</b>   |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

|  |  |  |   |
|--|--|--|---|
| 19a. DATE OF OPERATION<br><b>2/9</b>   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>DEC 19 78</b> to <b>JUNE 16 19 79</b> , that (I) (we) lost<br>saw the deceased alive on <b>JUNE 15 19 79</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |   |
| 22b. SIGNATURE<br><b>Neil G Meade MD</b>   | DEGREE<br><b>MD</b>  | 22c. DATE SIGNED<br><b>6-16-79</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>NEIL A. MEADE</b>  | 22e. ADDRESS<br><b>6501 LAMMONT ROAD CITICUSLY, MD</b>                 |  |   |

|   |                             |  |   |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>6/19/79</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FORT LINCOLN CEM.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BRENTWOOD P.G. MD.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS GASCLIS SONS, PA</b> |                             | ADDRESS<br><b>HYATTSVILLE, MD.</b>                             | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 19 1979</b>                     |
|   |                             | 25b. REGISTRAR'S SIGNATURE<br><b>Richard M. Brady</b>          |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

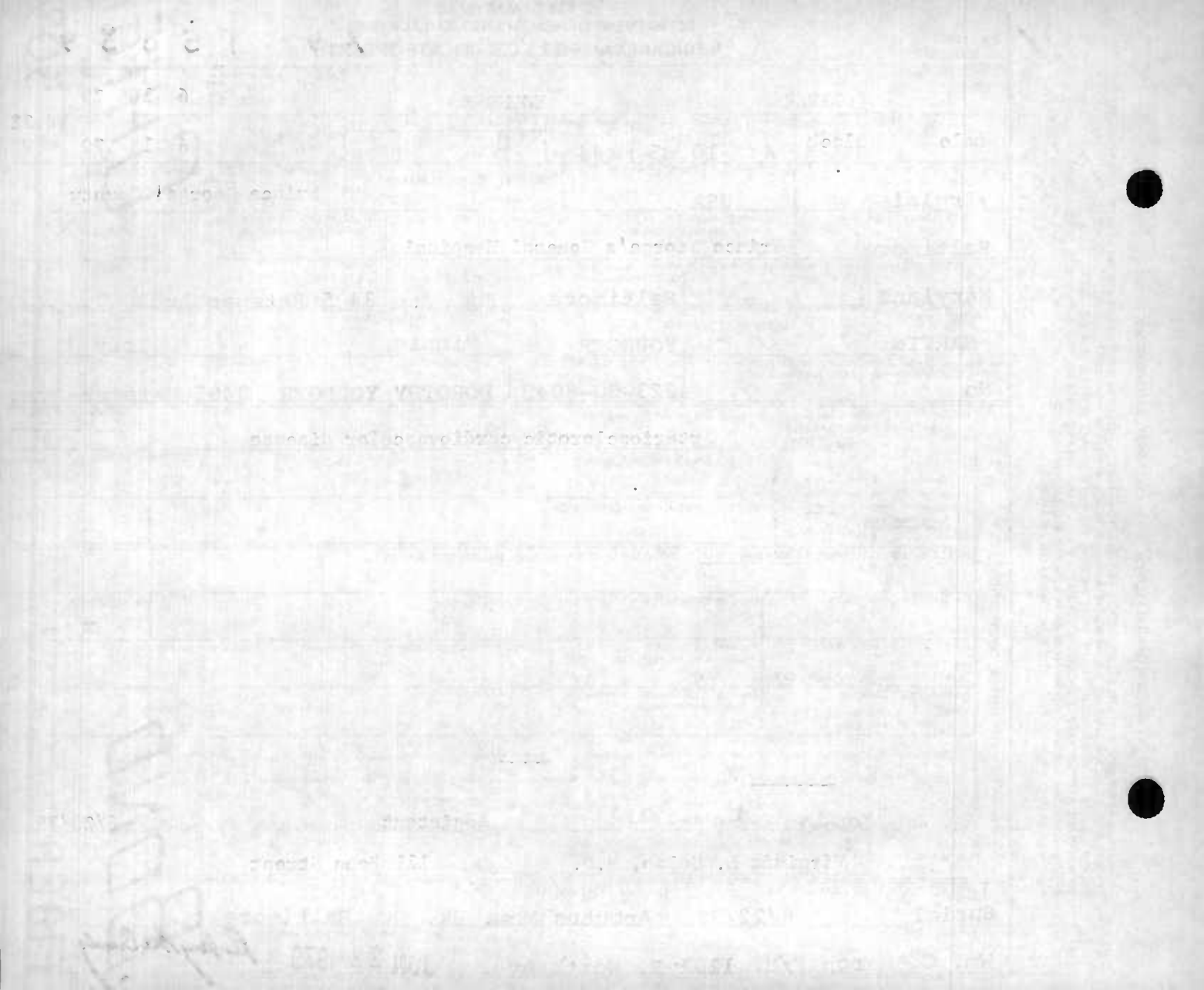
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                         |   |   |   |                  |   |                       |  |                            | REG. NO. 15659   |  |
|--|-------------------------|---|---|---|------------------|---|-----------------------|--|----------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>OLIVER YOUNGER</b>  |                         |   |   |   |                  |   |                       |  |                            | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 18 1979</b> |  |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>black</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>4 10 35</b>   | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>44 YRS.</b> | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR <b>6 18 1979</b>                                     | 7b. HOUR <b>18:32</b> |  | 7d. P.M.                   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Prince George's County</b>                           |                       |  | MD.                        |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Prince George's General Hospital</b> |   |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |                       | 12b. KIND OF BUSINESS OR INDUSTRY                    |                            |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |                         |   |   |   |                  |   |                       |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Prince George's</b>   |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                       | 13e. STREET ADDRESS<br><b>3405 Bateman Ave.</b>      |                            |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>MARTIN YOUNGER</b>  |                         |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Minnie Irby</b>   |                  |   |                       |  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |                         |   |   | 16b. SOCIAL SECURITY NO.<br><b>223-50-8042</b>  |                  | 17. INFORMANT ADDRESS<br><b>DOROTHY YOUNGER 3405 Bateman Ave.</b>                               |                       |  |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br><b>4292</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                         |   |   |   |                  |   |                       |  |                            |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |                         |   |   |   |                  |   |                       |  |                            |  |  |
| 19a. DATE OF OPERATION   |                         |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                  |   |                       |  |                            | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                   |                       |  |                            |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         |   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |                  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                       |  |                            |  |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |   |   |                  |   |                       |  |                            |  |  |
| ACTUAL SIGNATURE <b>Virginia L. Dolan</b>  |                         |   |   |   |                  | TITLE (SPECIFY)<br><b>Assistant</b>   |                       |  | DATE SIGNED <b>6/20/79</b> |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>   |                         |   |   |   |                  | ADDRESS <b>111 Penn Street</b>  |                       |  |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |                         |   |   | 23b. DATE<br><b>6/22/79</b>   |                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>                                   |                       |  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>                                       |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Wm. C. March F/H, 1101 E. North Ave.</b>  |                         |   |   |   |                  | 25a. DATE REC'D. BY REGISTRAR<br><b>JUN 22 1979</b>   |                       | 25b. REGISTRAR'S SIGNATURE<br><i>Robert M. Kelly</i> |                            |  |  |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGE 5. RETAIN PAGE 5 FOR YOUR FILE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR 415 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15660

|  |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |                                   |  |  |  |   |  |      |  |       |  |          |  |  |  |
|--|--|---------|--|---|--|-------------------|--|--|--|---|--|---|--|-------|--|-----------------------------------|--|--|--|---|--|------|--|-------|--|----------|--|--|--|
| 1. FOR STATE REGISTRAR   |  |         |  |   |  |                   |  |  |  | 2a. DATE KNOWN OF DEATH                                     |  |   |  |       |  |                                   |  |  |  | MONTH   |  | DAY  |  | YEAR  |  | 2b. HOUR |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |         |  |   |  |                   |  |  |  | 2a. DATE KNOWN OF DEATH                                     |  |   |  |       |  |                                   |  |  |  | MONTH   |  | DAY  |  | YEAR  |  | 2b. HOUR |  |  |  |
| JOHN H. ZUROMSKI   |  |         |  |   |  |                   |  |  |  | 6   |  |   |  |       |  |                                   |  |  |  | 1   |  | 1979 |  | 12:37 |  |          |  |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS) |  | IF UNDER 1 YR  |  | IF UNDER 24 HRS.  |  | 7c. DATE PRONOUNCED DEAD                                      |  | MONTH |  | DAY                               |  | YEAR   |  | 2d. HOUR  |  |      |  |       |  |          |  |  |  |
| male   |  | white   |  | March 11 1943   |  | 36 YRS.           |  |  |  |   |  | 6   |  | 2     |  | 1979                              |  | a  |  |   |  |      |  |       |  |          |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |  |       |  |                                   |  |  |  |   |  |      |  |       |  |          |  |  |  |
| Washington, D.C.   |  |         |  | U.S.A.  |  |                   |  |  |  |   |  | Prince George's Co. MD.                                       |  |       |  |                                   |  |  |  |   |  |      |  |       |  |          |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |                   |  |  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  |       |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |   |  |      |  |       |  |          |  |  |  |
| Cheverly   |  |         |  | Prince George's Gen. Hosp.  |  |                   |  |  |  |   |  | Laborer   |  |       |  | Farm                              |  |  |  |   |  |      |  |       |  |          |  |  |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |         |  |   |  |                   |  |  |  | 13d. INSIDE CITY LIMITS?                                    |  |   |  |       |  |                                   |  |  |  | 13e. STREET ADDRESS   |  |      |  |       |  |          |  |  |  |
| 13a. STATE   |  |         |  |   |  |                   |  |  |  | 13b. COUNTY   |  |   |  |       |  |                                   |  |  |  | 13c. CITY OR TOWN   |  |      |  |       |  |          |  |  |  |
| Maryland   |  |         |  |   |  |                   |  |  |  | Montgomery  |  |   |  |       |  |                                   |  |  |  | Poolesville   |  |      |  |       |  |          |  |  |  |
| 14. FATHER'S NAME  |  |         |  |   |  |                   |  |  |  | 15. MOTHER'S MAIDEN NAME                                    |  |   |  |       |  |                                   |  |  |  |   |  |      |  |       |  |          |  |  |  |
| John J. Zuromski   |  |         |  |   |  |                   |  |  |  | Alicia E. Beck  |  |   |  |       |  |                                   |  |  |  |   |  |      |  |       |  |          |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)   |  |         |  |   |  |                   |  |  |  | 16b. SOCIAL SECURITY NO.                                    |  |   |  |       |  |                                   |  |  |  | 17. INFORMANT   |  |      |  |       |  |          |  |  |  |
| No   |  |         |  |   |  |                   |  |  |  | N/A   |  |   |  |       |  |                                   |  |  |  | 216-40-7664   |  |      |  |       |  |          |  |  |  |
|  |  |         |  |   |  |                   |  |  |  | Alicia Zuromski   |  |   |  |       |  |                                   |  |  |  | 5806 Preston Ct. Apt. 182 Alexandria, Virginia                                |  |      |  |       |  |          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |      |  |       |  |          |  |  |  |
| PART I DEATH WAS CAUSED BY:  |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |                                   |  |  |  |   |  |      |  |       |  |          |  |  |  |
| IMMEDIATE CAUSE (a) Multiple thoracic injuries   |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |                                   |  |  |  |   |  |      |  |       |  |          |  |  |  |
| 8150   |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |                                   |  |  |  |   |  |      |  |       |  |          |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.  |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |                                   |  |  |  |   |  |      |  |       |  |          |  |  |  |
| (b)  |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |                                   |  |  |  |   |  |      |  |       |  |          |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |                                   |  |  |  |   |  |      |  |       |  |          |  |  |  |
| (c)  |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |                                   |  |  |  |   |  |      |  |       |  |          |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.  |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |                                   |  |  |  |   |  |      |  |       |  |          |  |  |  |
| 19a. DATE OF OPERATION   |  |         |  |   |  |                   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |  |       |  |                                   |  |  |  | 20. AUTOPSY?  |  |      |  |       |  |          |  |  |  |
|  |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |                                   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  |      |  |       |  |          |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |         |  |   |  |                   |  |  |  | 21b. TIME OF INJURY   |  |   |  |       |  |                                   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |      |  |       |  |          |  |  |  |
| 11:30 P.M. 6-1-1979  |  |         |  |   |  |                   |  |  |  | Driver in pick-up truck/fixed object collision              |  |   |  |       |  |                                   |  |  |  |   |  |      |  |       |  |          |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK  |  |         |  |   |  |                   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |   |  |       |  |                                   |  |  |  | 21f. LOCATION   |  |      |  |       |  |          |  |  |  |
| road   |  |         |  |   |  |                   |  |  |  | Rt. 450 bet. Rt. 193 & Rt. 564 P.G.                         |  |   |  |       |  |                                   |  |  |  | Md.   |  |      |  |       |  |          |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |         |  |   |  |                   |  |  |  |   |  |   |  |       |  |                                   |  |  |  |   |  |      |  |       |  |          |  |  |  |
| ACTUAL SIGNATURE   |  |         |  |   |  |                   |  |  |  | TITLE (SPECIFY)   |  |   |  |       |  |                                   |  |  |  | DATE SIGNED   |  |      |  |       |  |          |  |  |  |
| Ann M. Dixon, M.D.   |  |         |  |   |  |                   |  |  |  | Assistant   |  |   |  |       |  |                                   |  |  |  | 6-3-79  |  |      |  |       |  |          |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)  |  |         |  |   |  |                   |  |  |  | ADDRESS   |  |   |  |       |  |                                   |  |  |  |   |  |      |  |       |  |          |  |  |  |
| Ann M. Dixon, M.D.   |  |         |  |   |  |                   |  |  |  | 111 Penn St.  |  |   |  |       |  |                                   |  |  |  |   |  |      |  |       |  |          |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL  |  |         |  |   |  |                   |  |  |  | 23b. DATE   |  |   |  |       |  |                                   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |      |  |       |  |          |  |  |  |
| Burial   |  |         |  |   |  |                   |  |  |  | June 5 1979   |  |   |  |       |  |                                   |  |  |  | Ft. Lincoln Cemetery  |  |      |  |       |  |          |  |  |  |
| 24. FUNERAL DIRECTOR   |  |         |  |   |  |                   |  |  |  | 25a. DATE REC'D. BY REGISTRAR                               |  |   |  |       |  |                                   |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |      |  |       |  |          |  |  |  |
| Robert G. Beall Lanham   |  |         |  |   |  |                   |  |  |  | JUN 11 1979   |  |   |  |       |  |                                   |  |  |  | F.H. Lanham, Md. 20801  |  |      |  |       |  |          |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

9 1 5 6 6 1

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 2a. DATE OF DEATH  |  | 2b. HOUR  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Many</i>   |  | 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>BLACK</i>   |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>BLACK</i>  |  | 5. DATE OF BIRTH<br>MONTH <i>1</i> - DAY <i>24</i> - YEAR <i>06</i>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>MARYLAND</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><i>Clinton</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Clinton Community Hospital</i>           |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Housewife</i>  |  |
| 13a. STATE<br><i>MD.</i>  |  | 13b. COUNTY<br><i>PR. GEORGE</i>   |  | 13c. CITY OR TOWN<br><i>BRADBURY HEIGHTS</i>  |  |
| 14. MOTHER'S NAME<br>FIRST <i>WALTER</i> MIDDLE <i>JOHNSON</i> LAST <i>CATHERINE</i>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <i>CATHERINE</i> MIDDLE <i>RASIER</i> LAST <i>RASIER</i>   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>NO</i>   |  |
| 17. INFORMANT<br><i>MARION YOUNG</i>  |  | 18. SOCIAL SECURITY NO.<br><i>578-54-6497</i>  |  | 19. ADDRESS<br><i>SAME AS ITEM 13</i>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Massive MI</i><br><i>410-</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>ASHD + Hypertension</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i>   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6/11/79</i> , 19 <i>79</i> , to <i>6/11/79</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>6/11/79</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><i>M. MOHSSER</i>   |  | DEGREE<br><i>MD</i>  |  | 22c. DATE SIGNED<br><i>6-11-79</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>M. MOHSSER - MD</i>   |  | 22e. ADDRESS<br><i>301 - Central Av. Waldorf, MD 20676</i>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <i>BURIAL</i>  |  | 23b. DATE<br><i>6-16-79</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>LINCOLN MEMORIAL CEM</i>   |  |
| 23d. LOCATION<br>CITY OR TOWN <i>SUITLEND</i> COUNTY <i>P.G.</i> STATE <i>MD</i>  |  | 24. FUNERAL DIRECTOR<br>NAME <i>G.P. KALAS</i> ADDRESS <i>6160 OXON HILL RD.</i>   |  | 25a. DATE FILED BY REGISTRAR<br><i>JUN 15 1979</i>  |  |

1 0 0 0 1 2 7